

Reform and Oversight Efforts: Los Angeles County Sheriff's Department

July through September 2026

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ABOUT QUARTERLY REPORTS

Quarterly reports provide an overview of the Office of Inspector General's regular monitoring, auditing, and review of activities related to the Los Angeles County Sheriff's Department (Sheriff's Department) over a given three-month period.[1] This quarterly report covers Department activities and incidents that occurred between July 1 and September 30, 2026, unless otherwise noted. Quarterly reports may also examine issues of interest. This report includes special sections on the following topics:

- Law Enforcement Responses to Protests: The Columbus Model
- Update on Deputy-Gang Investigations
- Vehicle Pursuits – Using Technology to Reduce Traffic Collisions
- The Sheriff's Department's ALPR Audit
- Review of the Center for Policing Equity's Justice Navigator Assessments
- Status of Labor Negotiations on Measure R and AB 847
- Discussion of the Auditor-Controller's Reviews of the Sheriff's Department's
    - Incident Reporting Process
    - Internal Affairs Process
- *Rosas* Update

This past quarter, the Office of Inspector General published three reports on oversight of the Sheriff's Department:

- *An Analysis of a Sample of Title 15 Safety Checks*
- *Eighth Report Back on Meeting the Sheriff's Department's Obligations Under Senate Bill 1421*
- *Fifteenth Report Back on Implementing Body-Worn Cameras in Los Angeles County*

[1] This report refers to the Sheriff's Department, the Department, or LASD when referencing the Los Angeles County Sheriff's Department. The Office of Inspector General is also referred to as OIG in some places throughout the report.

MONITORING SHERIFF'S DEPARTMENT'S OPERATIONS

Deputy-Involved Shootings

The Office of Inspector General reports on all deputy-involved shootings in which a deputy intentionally fired a firearm at a human, or intentionally or unintentionally fired a firearm and a human was injured or killed as a result. During this quarter, there were five incidents in which people were shot or shot at by Sheriff's Department personnel. Three people died as a result, and one person suffered injuries and was admitted to the hospital.

Office of Inspector General staff were notified of the deputy-involved shootings and responded to four of the five shootings under the revised office protocol, which states that staff members assigned to the rollout team will respond to the scene of deputy-involved shootings during the workday.[2]

The Sheriff's Department maintains a page on its website listing deputy-involved shootings that result in injury or death, with links to incident summaries and video.[3]

The information in the following shooting summaries is based on the information provided by the Sheriff's Department at the Critical Incident Review (CIR) for the shooting and the information on the Department's website, including the written summaries and Critical Incident Briefings.[4] The information presented at CIR, in the written summary, and in the Critical Incident Briefing is preliminary in nature. Statements of deputies and witnesses are not provided until the Sheriff's Department completes its investigation.

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[2] On May 4, 2026, Office of Inspector General staff began responding to the scene of in-custody deaths during the workday. Deputy inspectors general and inspectors are assigned to the deputy-involved-shooting and in-custody-death rollout teams.

[3] Penal Code section 832.7(b)(1)(A)(i) requires that in response to a Public Records Act request, records relating to the report, investigation, or finding of an "incident involving the discharge of a firearm at a person by a peace officer or custodial officer" be made available. Delaying the availability of some information is permissible if certain criteria are met. On April 10, 2026, OIG inquired as to whether non-hit shootings meeting the criteria in this subsection are posted on the website or whether LASD has any plans to include non-hit shootings on its deputy-involved shootings transparency page. The Department replied that it is in the process of determining the answer.

[4] Manual of Policy and Procedures (MPP) section 3-09/330.00 Critical Incident Review Panel identifies what is a critical incident and describes the process for reviewing such incidents.

Lakewood: Hit Shooting – Fatal

On July 24, 2026, at approximately 8:48 p.m., Lakewood Station deputies were dispatched to an apartment complex after a caller reported that a man with a gun would not leave their home. When deputies arrived, the victim contacted the deputies and reported that she had asked the man to leave because he was causing a disturbance, pushed her, and pointed a gun at her. She provided a description of the suspect's clothing. As the deputy obtained information from the victim, a person matching the suspect's description, and later confirmed to be the suspect, was located nearby.

Multiple deputies arrived at the suspect's location. The deputies contacted the suspect, with at least one deputy pointing a gun at the suspect while commanding the suspect to stop, get his hands up, turn around, and not to reach for anything.[5] While the suspect raised his hands, the suspect ignored the other commands, put his backpack on, and began walking away. At least two deputies ordered the suspect to get on the ground and the suspect complied with this command.

One deputy deployed a Taser 10 but the initial deployment was ineffective. A second deployment by the deputy was effective causing the suspect to fall onto the sidewalk. While on the ground, the suspect rolled from his front to back despite commands to stay on his stomach. At least one deputy observed the gun in the suspect's waistband and yelled that the suspect was reaching towards the gun. One deputy, who announced to the others that he was in command, continued to order the suspect not to reach for anything. While the suspect stated that he was not reaching for anything, the suspect reached for his backpack, pushed it away, and then reached towards his gun, which was visible next to the suspect on the sidewalk. When the suspect again reached, three of the deputies fired at him; a total of 17 rounds were fired.
A .40 caliber semiautomatic gun with a loaded magazine was recovered at the scene.

Deputies rendered medical aid and the suspect was transported to the hospital where he was pronounced deceased

The Sheriff's Department posted a written summary and a Critical Incident Briefing of this incident on the LASD Transparency page for Deputy-Involved Shootings.

Areas for Further Inquiry

1. Did the deputies develop a tactical plan before all the deputies arrived at the suspect's location?

[5] It is unknown if all deputies had their guns drawn when first encountering the suspect.

2. Were the suspect's movements while on the ground deliberately in opposition to the commands to remain on his stomach or was the suspect responding to the Taser?

Lancaster: Hit Shooting – Non-Fatal

On September 7, 2026, at approximately 9:46 a.m., Lancaster Station received a call for service regarding a possible domestic violence incident involving a man attempting to force a woman into a vehicle. While deputies were en route, employees of the business called to report that they had observed the male suspect holding a handgun. The call was subsequently upgraded to a person-with-a-gun incident.

Upon arrival, deputies observed the suspect holding the victim in front of the location. The suspect was holding the woman with one hand around her neck and a handgun with the other. Deputies drew their handguns and ordered the suspect to drop the weapon. The suspect sat on the curb while continuing to hold onto the victim and pointed the weapon at the victim, at himself, and at deputies. Two deputies fired their weapons, striking the suspect multiple times. The woman was able to break away from the suspect and was not injured.

Following the shooting, deputies approached the suspect and rendered aid until fire department personnel arrived. The suspect was transported to a hospital for treatment.

The body-worn camera video included in the Critical Incident Review shows that the involved deputies activated their cameras before the shooting. However, because of camera positioning and various obstructions, the suspect's actions were difficult to discern in real time.

At the time of the Critical Incident Review, homicide detectives had not yet interviewed the involved deputies. Consequently, the specific circumstances and information that prompted the deputies to fire their weapons at that moment are unknown.

The Sheriff's Department posted a written summary and a Critical Incident Briefing of this incident on the LASD Transparency page for Deputy-Involved Shootings.

Areas for Further Inquiry

1. When the first deputies arrived on scene, did they discuss a tactical plan?
2. Was the use of less-lethal weapons an option?
3. Was it tactically sound to fire on the suspect while he was holding the victim?
4. Did the backdrop of the shooting also present a risk to bystanders?

5. Was it tactically sound for the deputies to leave cover and advance toward the suspect?

6. Should the Department have directed businesses in the immediate area to lock down?

Civil Management Bureau: Hit Shooting – Fatal

On September 21, 2026, at approximately 9:34 a.m., two deputies from the Civil Management Bureau were serving an eviction notice at a business in Claremont when a citizen flagged them down and told them that a man was rummaging through the inside of his vehicle at the gas station. As the deputies walked through the parking lot between the gas station and the eviction location, the suspect ran toward them with a knife in his hand, stating among other things, "you guys gotta to kill me." Both deputies retreated to create distance, with one taking cover behind a nearby vehicle. The suspect then charged the other deputy who fired three shots at the suspect as he continued running toward the deputy. The other deputy did not fire. One deputy went back to the patrol car to initiate a radio call because their assigned radios were not working while the other remained at the scene. The suspect died at the scene. Two knives were recovered.

The Sheriff's Department posted a written summary and a Critical Incident Briefing of this incident on the LASD Transparency page for Deputy-Involved Shootings.

Areas for Further Inquiry

1. Did the deputies have time to de-escalate and/or to use less-lethal force?

2. Did the witness inform deputies that the suspect had a knife?

3. Did the backdrop of the shooting endanger any civilians or Department personnel?

4. Why were the radios not functioning?

Lakewood Station: Hit Shooting – Fatal

On Sunday, September 27, 2026, Lakewood Station dispatch received a call reporting that there was blood on their neighbor's window and that through the window they could see their neighbor lying face down covered in blood. Based on the information, the dispatcher tagged the call as a rescue and medical aid call.

When the first deputy arrived at the scene, the deputy verified the information with the caller. The deputy observed blood on the window and secured the exterior area of the home while waiting for additional deputies and Fire Department personnel to arrive. The deputy removed the window screen, which was mangled and had blood on it, and drew

the blinds open for a better visual of the inside. The deputy observed a woman lying face down in a pool of blood.

A second deputy and Fire Department personnel arrived at the scene. The deputies coordinated their entry to secure the scene and assist the victim, while the Fire Department personnel remained outside. One deputy entered the window and unlocked the front door to let the second deputy in.

Upon entering the kitchen from the living room, the deputies encountered the suspect lying on the kitchen floor. The suspect raised a gun at the deputies, and a deputy-involved shooting occurred. Both the suspect and the elderly woman were pronounced dead at the scene. A loaded .32 semi-automatic handgun, a .38 caliber revolver, and a 12-gauge shotgun were recovered from the scene.

The Sheriff's Department posted a written summary and a Critical Incident Briefing of this incident on the LASD Transparency page for Deputy-Involved Shootings.

Areas for Further Inquiry

1. Could the deputies have looked into other windows to determine if there were any suspects in the home?
2. Did the deputies attempt to call out or see if anyone was in the kitchen prior to entering the kitchen?

East Los Angeles: Hit Shooting – Non-Fatal

On September 28, 2026, at approximately 4:16 a.m., East Los Angeles Station deputies received a call for service regarding a possible domestic violence incident involving two women in Cudahy. The caller stated that the female suspect had assaulted her girlfriend earlier in the evening and then followed her to a different location while armed with a gun. Upon arrival, the two responding deputies witnessed an argument occurring outside the location between multiple parties. As deputies began moving down the driveway to approach the parties, one of the women produced a firearm and began firing at the parties she had been arguing with, striking two people. Both deputies immediately opened fire, hitting the suspect at least once in the torso. Deputies rendered aid to the victims and the suspect until medical personnel arrived. The suspect and the two victims, one of whom is a minor, were transported to local hospitals for treatment. A loaded 9mm semiautomatic handgun was recovered at the scene.

The Sheriff's Department posted a written summary and a Critical Incident Briefing of this incident on the Transparency page for Deputy-Involved Shootings.

Areas for Further Inquiry:

1. Were concerns related to the backdrop considered given the proximity of the victims to the suspect?

2. Because the caller alerted dispatch to the fact that the suspect had a firearm, should additional units have been assigned initially?

District Attorney Review of Deputy-Involved Shootings

The Sheriff's Department's Homicide Bureau investigates deputy-involved shootings in which a person is hit by a bullet, except for deputy-involved shootings that result in the death of an unarmed civilian, which California law requires the Attorney General (CA-DOJ) to investigate.[6] For shootings it investigates, the Homicide Bureau submits the completed criminal investigation of each deputy-involved shooting in Los Angeles County that results in a person being struck by a bullet to the Los Angeles County District Attorney's Office (District Attorney's Office or District Attorney) for review and possible filing of criminal charges.

Between July 1 and September 30, 2026, the District Attorney's Office posted memoranda on its website for one finding on a deputy-involved shooting case involving the Sheriff's Department's employees.[7] The District Attorney's Office declined to file charges in this case, as they determined that the use of force was not unlawful. The memoranda may be found on the District Attorney's website page for Officer-Involved Shootings. The following are the deputy-involved shootings posted on the website:

- The March 30, 2024, fatal shooting of Adrian Agustin Pilar by Deputies Andrew Aselin and Jose Lopez Morfin.

- The May 3, 2024, non-fatal shooting of Isael Orellano by Deputy Juan Torres.

[6] In 2020, the California Legislature passed AB 1506, which requires that a state prosecutor investigate all shootings involving a peace officer that result in the death of an unarmed civilian. *See* A.B. 1506 (McCarty 2020) (codified at Govt. Code § 12525.3). The Attorney General's findings in these investigations are reported in the section of this report below entitled *California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians*.

[7] The District Attorney's Office posts its decisions on deputy and officer-involved shootings on its website under Officer-Involved Shootings. The Office of Inspector General retrieves the information on District Attorney decisions from this webpage.

California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians

Under California law, CA-DOJ investigates any peace officer-involved shooting resulting in the death of an unarmed civilian and may issue written reports or file criminal charges against a peace officer, if appropriate.[8] No CA-DOJ investigations were opened during the third quarter of this year regarding shootings by deputies from the Sheriff's Department. All previous investigations regarding Department shootings are closed. During the third quarter of 2026, CA-DOJ issued no written reports regarding shootings involving Sheriff's Department deputies.

Homicide Bureau's Investigation of Deputy-Involved Shootings

For the present quarter, the Homicide Bureau reports that it has seven shooting cases involving Sheriff's Department personnel that remain open and under investigation. The oldest case in which the Homicide Bureau maintained an active investigation at the end of the quarter relates to a January 13, 2026 shooting in the city of Palmdale. For further information as to that shooting, please refer to the Office of Inspector General's report *Reform and Oversight Efforts: Los Angeles Sheriff's Department - January through March 2026*. The oldest case that the Homicide Bureau currently has open is a 2023 shooting in the city of Carson, which was submitted to the District Attorney's Office and for which the Department continues await a filing decision. This quarter, the Department reported it has sent five deputy-involved-shooting cases to the District Attorney's Office for filing consideration.

Internal Criminal Investigations Bureau

The Sheriff's Department's Internal Criminal Investigations Bureau (ICIB) reports directly to the Division Chief and the Commander of the Professional Standards Division. ICIB investigates allegations of criminal misconduct committed by Department personnel in Los Angeles County.[9]

The Sheriff's Department reports that ICIB has 73 active cases. This quarter, ICIB reports submitting 14 cases to the District Attorney's Office for filing consideration. The District Attorney's Office is still reviewing 44 cases previously submitted by ICIB for filing

[8] Government Code § 12525.3(b).

[9] Misconduct alleged to have occurred in other counties is investigated by the law enforcement agencies in the jurisdictions where the crimes are alleged to have occurred.

consideration. The oldest case open ICIB case was submitted to the District Attorney's Office in 2019 and involves conduct that occurred in 2018.

Internal Affairs Bureau

The Internal Affairs Bureau (IAB) conducts administrative investigations of policy violations by Sheriff's Department employees. It also responds to and investigates deputy-involved shootings and significant use-of-force cases. If the District Attorney declines to file criminal charges, IAB conducts an independent investigation to determine whether Department personnel violated any policies during the incident regardless of the District Attorney's decision not to prosecute. If the District Attorney files charges, IAB proceeds with a review for policy violations following the prosecution. If IAB identifies policy violations that the Department sustains, the Department may impose discipline up to and including termination.[10]

The Sheriff's Department also conducts administrative investigations at the unit level. The subject's unit and IAB determine whether an incident should be investigated by IAB or remain a unit-level investigation based on the severity of the alleged policy violations.

During this quarter, the Sheriff's Department reported opening 127 new administrative investigations. Of these 127 cases, 51 were assigned to IAB, 53 were designated as unit-level investigations, and 23 were entered as criminal monitors (in which IAB monitors an ongoing criminal investigation conducted by the Department or another agency). In the same period, IAB reports that 106 cases were closed by IAB or at the unit level. There are 461 administrative investigations pending, of which 323 are assigned to IAB and the remaining 138 are unit-level investigations.

Auditor-Controller's Review of the Sheriff's Department's Internal Affairs Process

The County of Los Angeles Department of Auditor-Controller (Auditor-Controller or A-C) evaluated the design of the Sheriff's Department's IAB processes in a report titled *Sheriff's Department – Internal Affairs Process Review*. Many of issues discussed in the A-C report reflect concerns noted by the Office of Inspector General in its report, *Review and Analysis of Misconduct Investigations and Disciplinary Process* (February 2021). Of primary importance are concerns with delays in referring investigations to IAB given that the one-year statutory deadline generally starts running at incident discovery. Delays mean that there is less time to investigate, which

[10] If a deputy were convicted of criminal charges and decertified by the Commission on Peace Officer Standards and Training, the deputy would be unable to be employed as a peace officer.

potentially impacts the rigor and thoroughness of the investigation. The A-C report also raised concerns about the lack of a tracking system to ensure that investigations are completed timely. The Office of Inspector General agrees with the recommendations in the A-C report.

Civil Service Commission Dispositions

The Civil Service Commission hears employees' appeals of major discipline, including discharges, reductions in rank, or suspensions of more than five days. Between July 1 and September 30, 2026, the Civil Service Commission issued final decisions in thirteen cases involving Sheriff's Department employees. In these thirteen cases, the Civil Service Commission sustained the Department's discipline in seven cases and reduced the discipline in one case. The Civil Service Commission vacated their decision in three cases as instructed by the Superior Court. In the remaining two cases, the Civil Service Commission did not sustain the Department's discipline. The Civil Service Commission reports its actions, including final decisions, in minutes of its meetings posted on the County's website for commission publications.

The Sheriff's Department's Use of Unmanned Aircraft Systems

According to data posted by the Sheriff's Department, it deployed its Unmanned Aircraft Systems (UAS) 24 times between July 1 and September 30, 2026.

The Office of Inspector General continues to recommend that the Sheriff's Department provide more specific information regarding the use of UAS for a "high risk tactical operation." Circumstances justifying use of a UAS for a search might include exigent circumstances, a reasonable suspicion that a crime is occurring, probable cause to conduct a search, or the execution of a search warrant. The law recognizes these reasons for conducting a search as legal under the Fourth Amendment of the United States Constitution, which does not have an exception for a warrantless search based on a "high risk tactical operation."[11]

Historically, members of the public have supported drone usage in law enforcement but have requested usage be limited to activity that provides the greatest benefit to life and safety, and that safeguards be in place to avoid usage encroaching into areas which are

[11] There are other exceptions to a search warrant and decisions on the legality of a search absent a warrant are decided by courts on a case-by-case basis. See *The Search Warrant Requirement in Criminal Investigations & Legal Exceptions*.

likely to result in excessive invasion of privacy. Imprecise categories and limited information can result in law enforcement action that undermines public trust.

Tracking Taser Use

On October 3, 2023, the Board of Supervisors (Board) passed a motion instructing the Sheriff's Department to revise its Taser policies and incorporate best practices from other law enforcement agencies to ensure its policies complied with State and Federal law.[12] The motion directs the Office of Inspector General to include in its quarterly reports to the Board the status of deputy compliance with updated policies and training, and documentation on the Department's taser use.

In May 2024, the Sheriff's Department launched a web dashboard reporting Taser usage by date range with options to narrow the result parameters by patrol or custody, patrol station or facility, incident type, or city.[13] The available data includes the result of the use of force (i.e., whether the use resulted in an injury). The Department Taser dashboard shows the following information for Taser usage:

- During the third quarter of 2026, the Department reports there were 60 Taser uses: 7 in Custody, 47 in Patrol Operations, 5 in Specialized Units and 1 in designated as *Blank*.[14]
- During the third quarter of 2026 there were 48 Taser uses that resulted in injury to the person tased. The dashboard does not specify the nature or extent of the injuries.[15]

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[12] As reported in OIG's report, *Report on the Sheriff's Department's Taser Policy, Training and Usage* (December 16, 2024), the Sheriff's Department updated its Taser policies.

[13] The Sheriff's Department Body-Worn Camera Unit tracks only Taser 10 usage, the Department's dashboard tracks all Taser usage.

[14] The Sheriff's Department reported that the Taser use designated as *Blank*, was a Taser use by its Operation Safe Streets specialized unit.

[15] In previous quarters, OIG reported on additional information from the Sheriff's Department, such as whether the suspect possessed a weapon, the number of Tasers deployed throughout the Department, and the number of Signal activations, because that information was provided to us in response to OIG's inquiry regarding Taser use information. The Department indicated its preference that OIG obtain the information from the LASD website. OIG requested that if the Department wants additional information included that the information be provided to OIG by 15 days after the end of the quarter for consideration as to inclusion.

Law Enforcement Responses to Protests: The Columbus Model

On July 17, 2025, *Policing and Society, An International Journal of Research and Policy*, published *The Columbus Model: Crowd Psychology, Dialogue Policing and Protest Management in the U.S.A.*[16] The article examines how the Columbus Division of Police (referred to here as the Columbus Police Department or CPD) developed and implemented a new protest policing strategy. CPD did this after widespread criticism of its response to the 2020 protests following the murder of George Floyd by a Minneapolis police officer.[17]

Columbus, Ohio, 2020 Protests and Aftermath

According to an Ohio State University (OSU) study, CPD deployed approximately 1,400 officers and arrested 147 people during the protests from late May to mid-July 2020.[18] Demonstrators sued CPD alleging violations of their constitutional right to freedom of speech, assembly, petition, and the right to due process, along with excessive force and failure to intervene.[19]

The litigation resulted in a $5.75 million settlement and a permanent federal injunction.[20] The injunction bars CPD from using the following against non-violent demonstrators absent an imminent threat to safety or property: tear gas, pepper spray, flash-bang grenades, rubber bullets, wooden pellets, batons, body slams, and kettling (confining a

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[16] Clifford Stott, Shahidul Hassan, Duane Mabry, Steve Dyer & Kolin Straub (2026) *The Columbus Model: crowd psychology, dialogue policing and protest management in the U.S.A., Policing and Society,* 36:2, 155-177.

[17] On May 25, 2020, Minneapolis police arrested George Floyd, a 46-year-old Black man, on an accusation of using a counterfeit $20 bill. Former officer Derek Chauvin knelt on Mr. Floyd's neck for more than nine minutes while he lay handcuffed and prone, and Mr. Floyd died. The four officers involved were fired and later criminally charged and convicted. *See* Evan Hill, et. al, *How George Floyd Was Killed in Policy Custody*, N.Y. Times, May 31, 2020 (Updated January 24, 2022); Amy Forliti, *In turnaround, Chauvin pleads guilty to violating George Floyd's civil rights*, L.A. Times, December 15, 2021; Amy Forliti, Steve Karnowski and Tammy Webber, *3 former police officer convicted of rights violations in George Floyd killing* February 24, 2022; Amy Forliti, Steve Karnowski and Mohamed Ibrahim, *Former police officer pleads guilty to manslaughter in George Floyd killing*, L.A. Times, May 18, 2022.

[18] Trevor L. Brown and Carter M. Stewart *Research evaluation of the City of Columbus' Response to the 2020 Protests*, John Glenn College of Public Affairs, The Ohio State University (2021).

[19] David Wells, *Federal Judge Stops Columbus, Ohio Police from Using Tear Gas on Protesters*, Courthouse News Service (April 30, 2021).

[20] Nadine El-Bawab, *City settles for $5/75 million with those Injured in 2020 summer protest*, ABC News (December 10, 2021).

crowd into a small area before a mass arrest).[21] It also requires officers to display their badge numbers, including on riot gear, and to keep their body-worn cameras activated when interacting with protesters.[22] The Columbus City Council amended the City's ordinance, and CPD updated its Division Directives and Emergency Operations Manual, to codify these requirements.[23]

The Columbus Model

After the injunction, CPD initiated a comprehensive review of its policing of protests. The article notes that many agencies rely on outdated crowd-psychology theories that treat crowds as irrational and dangerous. Those theories lead to aggressive tactics that can escalate conflict. CPD instead adopted a dialogue-based approach used in Europe and grounded in the Elaborated Social Identity Model (ESIM), a theory emphasizing legitimacy, communication, and proportional policing.

ESIM holds that a crowd is not a homogeneous group and that people do not abandon their individual identities within it. If police treat everyone in a crowd as dangerous or disorderly, crowd members may begin to see themselves as a unified group opposed to police. If police instead distinguish peaceful participants from unlawful ones and respond proportionately, conflict is less likely to escalate. Demonstrators who see policing as fair are also more likely to cooperate.

In June 2022, CPD deployed its Public Order and Public Safety (POPS) framework. POPS emphasizes dialogue, de-escalation, and gradual tactical deployment rather than immediate force. It relies on three groups: Arrest and Control Teams (ACT) positioned at the rear and perimeter, who focus on arresting individuals who commit or incite violence; plainclothes officers within the crowd; and Dialogue Officers, uniformed officers in blue vests who serve as liaisons between CPD and demonstrators.[24]

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[21] *Alsaada et al. v. City of Columbus et al.* United States District Court for the Southern District of Ohio, Eastern Division. Case No. 2:20-cv-3431, Opinion and Order, 30 Apr. 2021. Courthouse News Service.

[22] Id.

[23] Columbus City Code Section 1913.03 (2022) "Response to Non-Violent Protests; Use of Force and Deployment and Use of Equipment."; Columbus Division of Police Directives; 2.01, 2.04-2.05, 11.07, 3.07.

[24] Telephone Interview of Zachary Scott, Lieutenant, Columbus Police Department, by OIG staff (June 30, 2026 and *see* Steve Dyer, Sergeant, and Kolin Straub, Lieutenant, CPD, "Dialogue to Drive Public Safety" How the Columbus Model Is Redefining Public Order Policing," *Police Chief* Vol. 93, no. 6 (June 2026): [page 42].

CPD's "70/20/10 Model" holds that 70 percent of success comes from planning, negotiation, and rapport-building before an event. Another 20 percent comes from conduct during the event, and 10 percent from debriefing and follow-up afterward.[25] CPD training has three parts: the history of the 2020 protests and the injunction; review of body-worn camera video from past protest events to see how POPS operations are implemented; and mock protests in which officers practice identifying and negotiating with group leaders.[26]

The researchers studied more than 60 protest events between 2022 and 2024. These included LGBTQ+ events, Black Lives Matter demonstrations, and anti-war and pro-Palestinian protests. The researchers observed operations, reviewed body-worn camera video, and attended CPD planning and evaluation meetings. They observed that Dialogue Officers worked directly with protesters to reduce tension and encourage crowds to regulate themselves. In some cases, police facilitated marches that technically violated traffic laws rather than enforcing those laws aggressively, reasoning that preserving legitimacy reduced the risk of violence. This approach often prevented escalation and minimized arrests and use of force. Over time, it also improved trust between some protesters and police.

The model has faced internal resistance. Some CPD officers believe POPS undermines police authority, and Dialogue Officers have been publicly accused of being too friendly with protest groups because they used relationship-building tactics, such as informal gestures and communication. CPD reports, however, that attitudes are shifting as officers see more peaceful events and fewer uses of force. It also reports that Dialogue Officers are now requested frequently and that more permanent POPS positions are needed, since all POPS assignments are currently part-time.[27]

California Legislation on Law Enforcement Crowd Control

Since 2020, California has enacted two laws governing how law enforcement manages protests: Assembly Bill 48 (AB 48) and Senate Bill 98 (SB 98). Both took effect January 1, 2022. The Sheriff's Department implemented policies to comply with AB 48 in the Manual of Policy and Procedures (MPP) in sections 5-06/030.11 and

[25] Id. Dyer at 43.

[26] Id.

[27] Telephone Interview with Zachary Scott, Lieutenant, Columbus Police Department, (June 30, 2026).

5-06/030.12[28] and to comply with SB 98 in sections 2-04/070.100, 2-04/070.110, and 2-04/070.120.[29]

AB 48, codified in Penal Code sections 13652 and 13652.1, restricts the use of kinetic energy projectiles and chemical agents to disperse assemblies, protests, or demonstrations as follows:

- Employment of kinetic energy projectiles and chemical agents must be objectively reasonable to defend against a threat to life or serious bodily injury or to bring an objectively dangerous and unlawful situation under control.
- Employment of kinetic energy projectiles and chemical agents must be proportional to the threat.
- Before deployment, when objectively reasonable, officers must attempt de-escalation, give audible warnings, allow a reasonable opportunity to disperse, and make reasonable efforts to distinguish violent individuals from others.
- Officers employing kinetic energy projectiles and chemical agents must minimize the impact on bystanders, journalists, and medical personnel, and must provide or obtain aid for injured people when reasonable and safe.

AB 48 also sets these prohibitions and limits:

- Projectiles may not be aimed at the head, neck, or other vital organs.
- These weapons may not be used solely because of a curfew violation, a verbal threat, or noncompliance with an officer's directive.
- Only an on-scene commanding officer may authorize the use of tear gas.
- Only officers trained by the Commission on Peace Officer Standards and Training (POST) may deploy these weapons.

Agencies must post a summary of each deployment on their websites within 60 days, with the possibility to delay posting for just cause, but no later than 90 days from the date of the incident. The Sheriff's Department's reports are available on its AB 48 Transparency Page.

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[28] Los Angeles County Sheriff's Department, Manual of Policy and Procedures Section 5-06/030.11 Use of Less Lethal Weapons During Civil Unrest and Section 5-06/030.12, Use of Kinetic Energy Projectiles and Chemical Weapons to Disperse Assemblies, Protests, or Demonstrations.

[29] Manual of Policy and Procedures Sections 2-04/070.100 Access to Impacted Areas, 2-04/070.110 Media Access to Command Posts During Civil Disorder Events, 2-04/070.120 Detention, Investigation, or Arrest of Members of the Media.

While AB 48 covered kinetic energy projectiles and chemical agents, a more recent bill, SB 937, adds flash-bang grenades to the list of less-lethal weapons subject to Penal Code section 13652 and 13652.1. The bill becomes effective on January 1, 2027.

SB 98, codified at Penal Code section 409.7, extends statutory press protections to protests. Previously, those protections covered areas closed during emergencies and natural disasters (Penal Code section 409.5) but did not expressly extend to protest closures. Under SB 98:

- When officers close the area around a command post or establish a police line or rolling closure at a demonstration protected by the First Amendment, authorized representatives of the press may enter to gather and report information.
- Officers may not intentionally assault, interfere with, or obstruct the press.
- Journalists may not be cited for failure to disperse, curfew violations, or violating Penal Code section 148(a)(1) solely for newsgathering.
- A detained journalist must be permitted to contact a supervisory peace officer immediately to challenge the detention, unless circumstances make that impossible.

The law does not exempt journalists from other applicable laws.

Los Angeles County Sheriff's Department Sheriff's Response Team

The Sheriff's Response Team (SRT) is the Department's primary unit for protests and crowd control. SRT training covers the laws above and the related MPP sections. It also covers practical techniques: verbal commands, defensive and offensive use of shields and batons, formations for safe arrests and rendering of aid, and techniques for dispersal of passive protesters. Approximately 400 Department members have completed SRT training, which qualifies them under POST to deploy less-lethal weapons as AB 48 requires. SRT holds training twice a year, each session consisting of two days of instruction plus one day of weapons qualifications. SRT also trains surrounding agencies to improve coordination for multi-agency responses to protests and events. Separately, the Department reports that 97% of all Department members (not just SRT-trained deputies) have completed its AB 48 training video, which reportedly covers all of the law's requirements.

SRT places its members at events based on available intelligence. Training includes the Department's goal of protecting free expression for all viewpoints. SRT's dedicated Media Sergeants speak with the press at protests and demonstrations. Their role is to make sure deputies on the ground know who are press members, that journalists are in safe areas, and that journalists are provided with information regarding the protest. Individual Sheriff's stations also build relationships with local press. The Department

reports that most journalists want deputies to distinguish them from participants who are causing problems.

Recent Incidents

Despite these efforts, protests in Los Angeles County have led to lawsuits involving the Department's use of force. These include protests over Immigration and Customs Enforcement (ICE) activity and the "No Kings" demonstrations.

- ***The Southlander***: On June 7, 2025, *The Southlander* reporters Abraham Márquez and Ben Camacho were covering anti-ICE protests in Compton and Paramount. They allege that deputies struck them with less-lethal projectiles even though they had identified themselves as members of the press. Mr. Márquez was allegedly hit in the back and buttocks while fleeing. Mr. Camacho was allegedly struck in the knee and elbow while helping photojournalist Nick Stern, who had been hit by an explosive projectile.

- **Espejo:** Sergio Espejo sued the County for injuries he sustained at the June 14, 2025, "No Kings" protest in downtown Los Angeles.[30] Mr. Espejo alleges that he was waving an American flag and chanting "peaceful protest" near City Hall when an LASD deputy fired a flash-bang device that struck and exploded on his left hand. He underwent emergency surgery at Los Angeles General Medical Center, resulting in the amputation of the top portion of his left index finger.

In response to oversight concerns about the protection of media at demonstrations, the Department issued a newsletter highlighting its training and the policies discussed above.[31]

Conclusion

While the Sheriff's Department's policies comply with state law, the Department's policies and training do not focus on the ESIM-informed, dialogue-led protest policing that CPD has demonstrated can function more effectively. Strategies emphasizing communication, legitimacy, proportionality, and facilitation maintain order and protect

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[30] Zurie Pope, "Law enforcement violating rules on less-lethal weapons in ICE protests, critics say," *The Los Angeles Times,* July 11, 2025.

[31] L.A. County Sheriff's Department, Response to the Civilian Oversight Commission's Request for Follow-Up Data, Information, and Policies Relating to the Protection of Media in Demonstrations (November 6, 2025). The FOSS newsletter was rescinded and codified in MPP section 2-04/070.110, Media Access to Command Posts During Civil Disorder Events.

constitutional rights have been shown to be more efficacious than traditional force-heavy crowd-control methods. The Columbus Model sets a strong example for future reform of protest policing.

Recommendations for Sheriff's Department Training and Policies on Responses to Protests

1. The Sheriff's Department should explore training from the Columbus Police Department on the Columbus Model to improve its response to protests and other large gatherings.
2. The Sheriff's Department should revise its policies and training on flash-bang devices to comply with Senate Bill No. 937 before the law takes effect on January 1, 2027.
3. While exploring Columbus Model training, the Sheriff's Department should provide scenario-based training on Assembly Bill 48 and Senate Bill 98 requirements, including identifying and protecting members of the press, to all deputies, not only those deputies who are assigned to SRT.

Update on Deputy-Gang Investigations

Agreement with the Los Angeles County Professional Peace Officers Association

During a trial involving a Sheriff's Department employee who claimed he was unfairly denied a promotion, members of the Sheriff's Department command staff discussed that promotional candidates were asked about tattoos but the candidate's answer was not documented.[32] Former Assistant Sheriff Jill Torres, Assistant Sheriff Gerardo Pinedo, and Assistant Sheriff Myron Johnson each testified to an agreement between Sheriff Luna and the Los Angeles County Professional Peace Officers Association (PPOA) not to document any admission of subgroup or station tattoos during the promotion process for captain and above.[33] Former Assistant Sheriff Holly Francisco testified that the agreement with the employee unions not to document the information was to "protect the employee that's giving us the information." Assistant Sheriff Gerardo Pinedo testified that he was aware of the agreement with PPOA but was not aware whether it was written down or not.

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[32] Benjamin Torres v. County of Los Angeles, (C.D. Cal, No. CV25-04155-RGK).

[33] *See* trial testimony of Holly Francisco, March 3, 2026 at pages 181 to 184, trial testimony of Myron Johnson, March 4, 2026, at pages 280 and 285, trial testimony of Gerardo Pinedo, March 4, 2026, at pages 306 to 310, and trial testimony of Jill Torres on March 4, 2026, at pages 434 to 438.

In response to an inquiry by the Office of Inspector General, the Sheriff's Department confirmed that there is an agreement and that it is not in writing.

Ongoing Investigation into Deputy Subgroups

In the Office of Inspector General's Report, *Los Angeles County Sheriff's Department Legal Compliance Deputy Gangs* (February 26, 2024), a portion of the report regarding an ongoing investigation was redacted at the Sheriff's Department's request. OIG staff inquired as to the status of the investigation based on a request received by OIG to release the redacted portion. The redacted portion does not include any confidential information, but it does include the station where the alleged conduct occurred. In denying OIG's request to release the redacted portion, the Department noted that the investigation remains open. The Department declined to provide any additional information to OIG claiming confidentiality and that providing additional information would interfere with the investigation. In order to determine an approximate date by which the investigation needed to be concluded, OIG then inquired as to the statute of limitations of the crime being investigated. The Department asserted that even providing the statute of limitations would interfere with the investigation. The ordinance establishing the Office of Inspector General and state law provide that OIG is entitled to confidential information with the only limitation being that actions by OIG may not obstruct a criminal investigation. There is simply no merit to the claim that providing OIG with the statute of limitations would obstruct the investigation. In a conversation with the Interim Inspector General, a member of the Sheriff's command staff provided the explanation that the Department wanted to keep the circle of people with knowledge tight as the reason for withholding the information. The Department's position is not supported by law.

Office of Constitutional Policing and IAB Investigations of Deputy Secret Subgroups and Gangs

The Sheriff's Department Office of Constitutional Policing (OCP) has opened a total of 47 supervisory inquiries relating to deputy subgroup/clique/gang membership as of the close of the third quarter of 2026. Of those, 32 inquiries are closed, with 20 referred to IAB and 12 with no further action taken, leaving 15 pending inquiries. IAB opened investigations on 18 of the referrals from OCP. The IAB investigations of 14 of the referrals resulted in discipline in 5 cases; 5 investigations remain open.[34]

[34] One referral resulted in two IAB investigations, which explains why the total number of IAB investigations is 19 while there were 18 referrals.

To date, the Sheriff's Department has not identified a group by name, or other indicia, that meets the definition of a law enforcement gang under Penal Code section 13670.

On November 5, 2026, the Sheriff's Department implemented MPP 3-01/050.83 - *Prohibited Cliques: Employee Groups Which Violate Rights of Other Employees or Members of the Public*. The policy defines a prohibited clique. Due to the timing of the policy release, an analysis by the Office of Inspector General has not yet been completed.

Vehicle Pursuits and Code-3 Operations – Using Enhanced Technology to Reduce Collisions

The Sheriff's Department reported it began implementing new siren technology that uses low-frequency sound waves to alert drivers that an emergency vehicle is approaching.[35]

The Department's Communications and Fleet Management Bureau field-tested products from four vendors, evaluating features and technology, customer support, cost, and maintenance requirements, before selecting *SoundOff* Signal.

When a patrol vehicle responds to an incident with its emergency lights and siren activated, the system projects a deep sound wave that drivers can feel, not just hear. The sound penetrates closed vehicle cabins, helping alert drivers to approaching emergency vehicles, especially in heavy traffic or noisy environments.

The system operates alongside the Department's existing sirens and new emergency lighting technology, which is being introduced as part of the same deployment. The inclusion of the lighting technology was the primary reason for the selection of the *SoundOff* Signal system.

The Department began deploying the new technology across its fleet in May 2026 and. reports that the equipment requires no additional training. The Department ordered 440 units at a cost of $435 per unit, for a total cost of $191,400. As of September 2026, 340 units had been installed and deployed at most Sheriff's patrol stations countywide.

When reviewing on-duty traffic collisions, the Department's Executive Traffic Risk Review Committee will evaluate whether the involved patrol vehicle was equipped with the new siren system and whether the system played any role in the collision. The

[35] *The Los Angeles Times* reported on the Los Angeles Police Department's use of a similar system. Campa, *If you don't hear the siren, police are sure you'll feel the Rumbler*, L.A. Times (Aug. 10, 2026).

Department will also track changes in collision rates to assess the system's effectiveness over time.

The Sheriff's Department Automatic License Plate Reader Audit

Summary of LASD Audit

To ensure accountability and transparency in the Department's use of automatic license plate reader (ALPR) technology, the Board of Supervisors, by motion dated September 16, 2025, directed the Sheriff's Department to update its ALPR policy, report back to the Board, and to provide OIG and the Civilian Oversight Commission (COC) with "a semi-annual written report summarizing ALPR data or system access logs (redacted for the COC as legally necessary) that identifies the requesting entity, date range, and statutory authority relied upon to disclose information."

The Sheriff's Department prepared a series of reports for the Board, including its first audit report, which it sent to the Board on September 23, 2026.[36] The Department's Communications and Fleet Management Bureau's Advanced Surveillance and Protection (ASAP) Unit conducted this first audit covering January through June 2026.

MPP section 5-09/550.05 requires the Department to submit its audit report 90 days after the second and fourth quarters of each calendar year. Based on this timeline, OIG will report on the Department's ALPRs audits in its first and third quarterly reporting.

During the audit period, the users ran 77,562 queries in the Department's ALPR database. The Department audited 50 queries from each month, for a total of 300. Although the Department reported that no sampled query remained unsupported at the conclusion of the audit, eight of the sampled queries (approximately 3%) did not initially demonstrate a legitimate law enforcement purpose for the query consistent with Department policy. The justifications for these eight queries were deemed sufficient only after the auditors followed up with the users to obtain additional information or clarification.

Additionally, the audit did not confirm that each query was connected to a legitimate law enforcement purpose. It reviewed whether the stated justification was adequate, not whether it was true. A query could appear justified on its face but still constitute misuse if its underlying purpose was for an illegitimate law enforcement purpose.

[36] The COC conducted a virtual public forum titled "Tracking License Plates and Protecting Privacy," in which LASD and OIG participated. (May 6, 2026).

The Department's own policy states:

> The Department will make every reasonable effort to ensure that information retained is derived from credible and reliable sources which convey accurate, current, and complete information, including the relevant context in which the information was sought or received.

By accepting the justifications as stated in the queries with no further analysis, the Department cannot be certain that the *relevant context in which the information was sought or received* served a legitimate law enforcement purpose.

While OIG has no reason to suspect widespread misuse, an examination of the truthfulness of the information entered is necessary to confirm no misconduct occurred. OIG is not suggesting that all 77,562 entries be scrutinized, but at a minimum the 300 entries should be.

Finally, the audit report did not include what the Board's motion directed: a summary of ALPR data or system access logs that identify the requesting entity, date range, and statutory authority relied upon to disclose information.

Recommendations for Ensuring Compliance with ALPR Laws and Policies

1. The Department should train all ALPR users to enter a justification that specifies a legitimate law enforcement purpose for each query and includes any case information connecting the query to an investigation. OIG notes that the Department recently launched updated ALPR Privacy Policy Training via an online course. The training is mandatory for all personnel with access or may have access in the near future to any ALPR system. The training includes a knowledge assessment.

2. The Department's audit should verify that each audited query's justification is truthful and that the query is connected to an investigation or other legitimate law enforcement purpose.

3. The Department should include in its reporting the information directed by the Board: a summary of ALPR data or system access logs that identifies the requesting entity, date range, and statutory authority relied upon to disclose information.

Review of the Center for Policing Equity's Justice Navigator Assessments

In June 2026, the Center for Policing Equity (CPE), a nonprofit research organization, and the Sheriff's Department released Justice Navigator Assessments (JNAs) for eight

LASD patrol stations. [37] "These JNAs are data-driven analyses that identify racial disparities in police interactions, provide an opportunity for departmental policy and organizational change, and set the stage for practical conversations with community members."[38] Using data provided by LASD and supplemented with publicly available data, CPE analyzed pedestrian and vehicle stops at the eight stations from 2019 through 2023.[39] The assessments are published on CPE's Justice Navigator, an interactive online platform that gives communities and law enforcement agencies access to public safety analysis, policy insights, and community resources.[40]

The stations assessed were Carson, Century, Compton, East Los Angeles, Industry, Lakewood, South Los Angeles, and Temple. For each station, CPE examined policing data, alongside demographic and crime data, to identify which practices show patterns of racial disparity and what factors may be driving them.

OIG reviewed these assessments and summarized CPE's findings on pedestrian and vehicle stops and searches below.

Racial Disparities in Pedestrian Stops and Searches

CPE found no racial disparities in pedestrian search rates at six of the eight stations.[41] This review focuses on the two patrol stations where CPE found disparities: Compton and Century.

Compton Station

CPE defined pedestrian stops as "stops for which the recorded reason was anything other than 'traffic violations.'"[42] CPE's analysis of pedestrian stops at Compton Station from 2019 through 2023 identified several areas warranting continued oversight.

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[37] Center for Policing Equity, *The Center for Policing Equity Announces Release of a New CPE Justice Navigator Assessment for Los Angeles County's Sheriff's Department* (June 10, 2026).

[38] *Id.*

[39] CPE also analyzed use of force, calls for service, and officer-initiated activity, which fall outside the scope of this review.

[40] *See* Center for Policing Equity, *supra* note 15; *see also Justice Navigator*.

[41] *See* Center for Policing Equity, Justice Navigator, Pedestrian Stops: *Carson*; *Century*; *Compton*; *East LA* ; *Industry* ; *Lakewood* ; *South LA* ; *Temple*.

[42] Center for Policing Equity, *Compton, CA, 2024-Pedestrian Stops*, Justice Navigator.

Black people accounted for 39% of pedestrian stops, while Black residents made up 24% of the patrol area's population. Latinx people accounted for 56% of stops and 72% of the population.[43] CPE's analysis found that, after accounting for neighborhood crime, area poverty levels, and the share of Black residents, deputies stopped Black and White people at about the same rate. These neighborhood factors explained 52% of pedestrian stop frequency, leaving 48% unexplained, which likely reflects factors within the Department's control, such as Department policies and practice or deputy behavior.[44]

The analysis also found that deputies discovered contraband in only 29% of discretionary searches and that 26% of pedestrian stops ended with a warning or no action. Once stopped, Latinx pedestrians were searched 1.2 times as often as White pedestrians, while Black and White pedestrians were searched at about the same rate.[45] These findings support further examination of the reasons for pedestrian stops, the use and effectiveness of discretionary searches, and the extent to which departmental policies and deputy practices influence stop activity.

CPE noted that OIG previously identified significant underreporting of LASD stops in 2018 and 2019.[46] Although CPE found that excluding pre-2022 data did not materially change its results, it had no indication that the underlying reporting problems had been resolved.[47] This limitation is relevant when assessing the completeness and reliability of the data.

Century Station

CPE's analysis of pedestrian stops at Century Station from 2019 through 2023 found clear racial disparities, particularly for Black people. Black residents made up 11% of the patrol area's population, but Black people accounted for 22% of those stopped. Latinx residents made up 86% of the population and 73% of those stopped, and White residents made up 1% of the population and 4% of those stopped.[48]

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[43] *Id.*

[44] *Id.*

[45] *Id.*

[46] *Id.; see also* L.A. County Office of Inspector General, *The Sheriff's Department's Underreporting of Civilian Stop Data to the California Attorney General* (June 10, 2022).

[47] Center for Policing Equity, *supra* note 20.

[48] Center for Policing Equity, *Century, CA, 2024 – Pedestrian Stops*, Justice Navigator.

After adjusting for neighborhood crime, poverty, and the share of Black residents, CPE found that deputies stopped Black pedestrians 1.8 times as often as White pedestrians and Latinx pedestrians 1.3 times as often. Those neighborhood factors explained only 49% of stop frequency, and CPE concluded that factors within the Department's control, such as policy and practice or deputy behavior, likely play a role in the remaining stops.[49]

Once stopped, Latinx pedestrians were searched 1.3 times as often as White pedestrians, while Black and White pedestrians were searched at about the same rate. Deputies found contraband in only 21% of discretionary searches, although searches of Black and Latinx pedestrians found contraband somewhat more often than searches of White pedestrians. One-third of stops (33%) ended with a warning or no action, and the most common recorded reason for a stop was "suspicious person/behavior."[50] Overall, the findings point to racial disparities in who is stopped and searched that neighborhood conditions do not fully explain. The data limitations noted above for Compton Station apply here as well.[51]

Racial Disparities in Vehicle Stops and Searches

This section summarizes CPE's analysis of vehicle stops at eight patrol stations from 2019 through 2023.[52] CPE defined *vehicle stops* as stops for which deputies recorded the reason as a traffic violation. Moving violations include conduct such as speeding or running a red light. Non-moving violations include equipment problems, expired registration, and license checks. According to CPE, non-moving violation stops have little direct connection to road safety and are more likely to be pretextual, meaning a minor violation is used as a reason to stop someone for another purpose.[53] OIG has previously reported on racial disparities in traffic stops and made policy recommendations on crime suppression stops, which are often referred to as pretextual

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[49] *Id.*

[50] *Id.* A lack of specificity in describing suspicious person/behavior may suggest that the search was not constitutionally compliant. OIG recommends that the Department require more specificity justifying stops and searches to ensure legal compliance.

[51] *Id.*

[52] *See* Center for Policing Equity, Justice Navigator, Vehicle Stops: *Carson*; *Century*; *Compton*; *East LA*; *Industry*; *Lakewood*; *South LA*; *Temple*.

[53] *Id.* OIG agrees with CPE's assessment in this regard.

stops.[54] CPE defined discretionary searches as searches "that are not mandatory but instead based on deputies' discretion."[55]

*Who was stopped**

Station	Black	Latinx	White	Asian/Pacific Islander
Carson	24%	54%	12%	9%
Century	24%	73%	2%	**
Compton	39%	57%	2%	**
East LA	4%	89%	3%	**
Industry	4%	70%	8%	17%
Lakewood	16%	63%	12%	7%
South LA	48%	42%	7%	**
Temple	4%	55%	12%	26%

*CPE did not compare these figures to resident populations, because drivers often live outside the patrol area.[56]

**CPE did not report a figure for this group at this station.

Part 1: Moving vs. Non-Moving Violation Stops

At seven of the eight stations (excluding Lakewood Station), deputies recorded a larger share of stops of Black drivers for non-moving violations than stops of White drivers. The same was true for Latinx drivers at every station that reported a Latinx figure. At these seven stations, White drivers had a larger share of stops recorded as moving violations than Black drivers. At Lakewood, stop reasons were about the same for every group, and most stops (83%) were for moving violations. [57] The largest gap was at South Los Angeles, where 68% of stops of Black drivers were for non-moving violations, compared with 48% of stops of White drivers. At Temple and Industry stations, the gap was 11 to 14 percentage points for both Black and Latinx drivers.[58]

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[54] L.A. County Office of Inspector General, *Addressing Racial Disparities in Traffic Stops* (Mar. 2023).

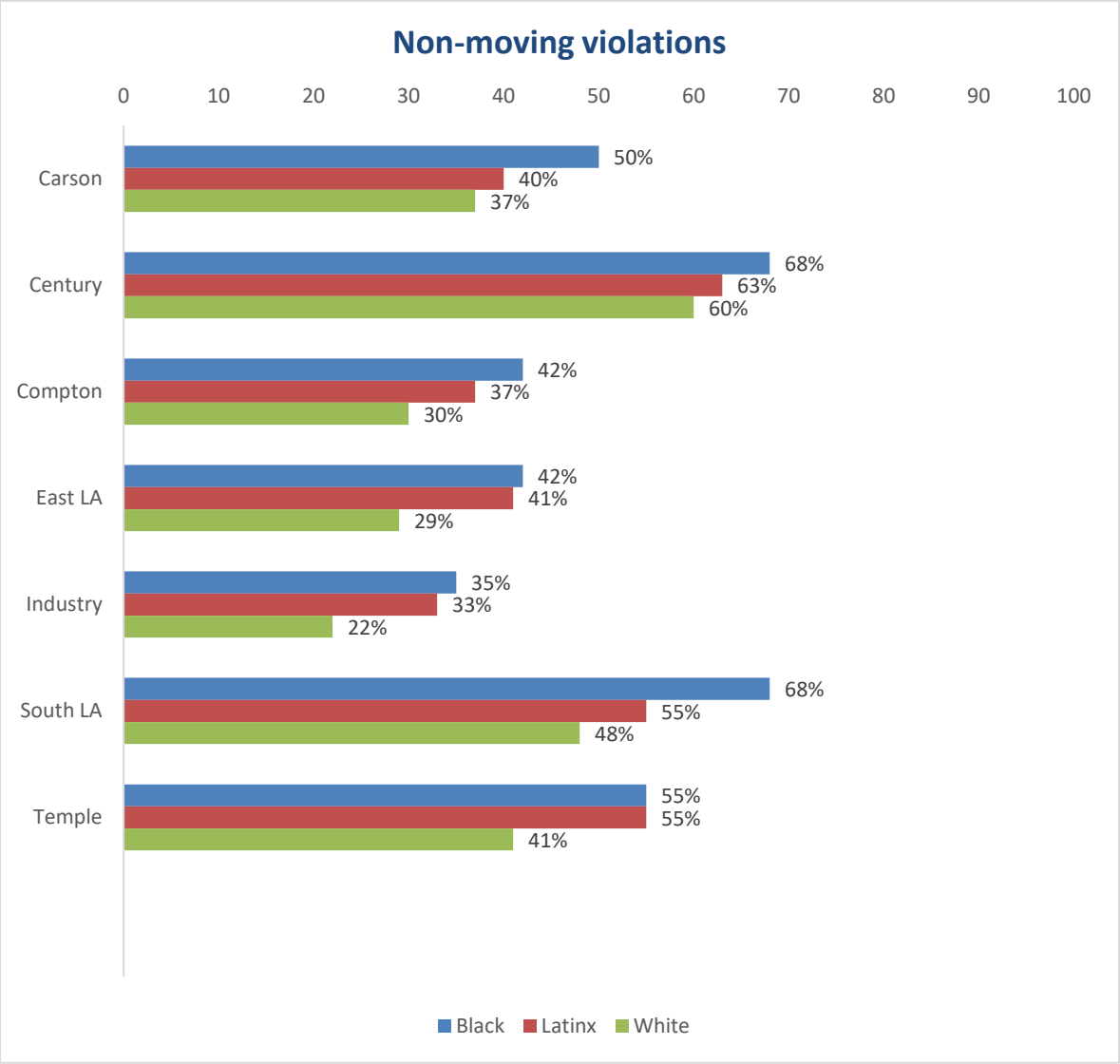
[55] Center for Policing Equity, *supra*. CPE's category of "discretionary" searches includes searches for which no reason was recorded. Some of these may have been mandatory searches that deputies did not properly document.

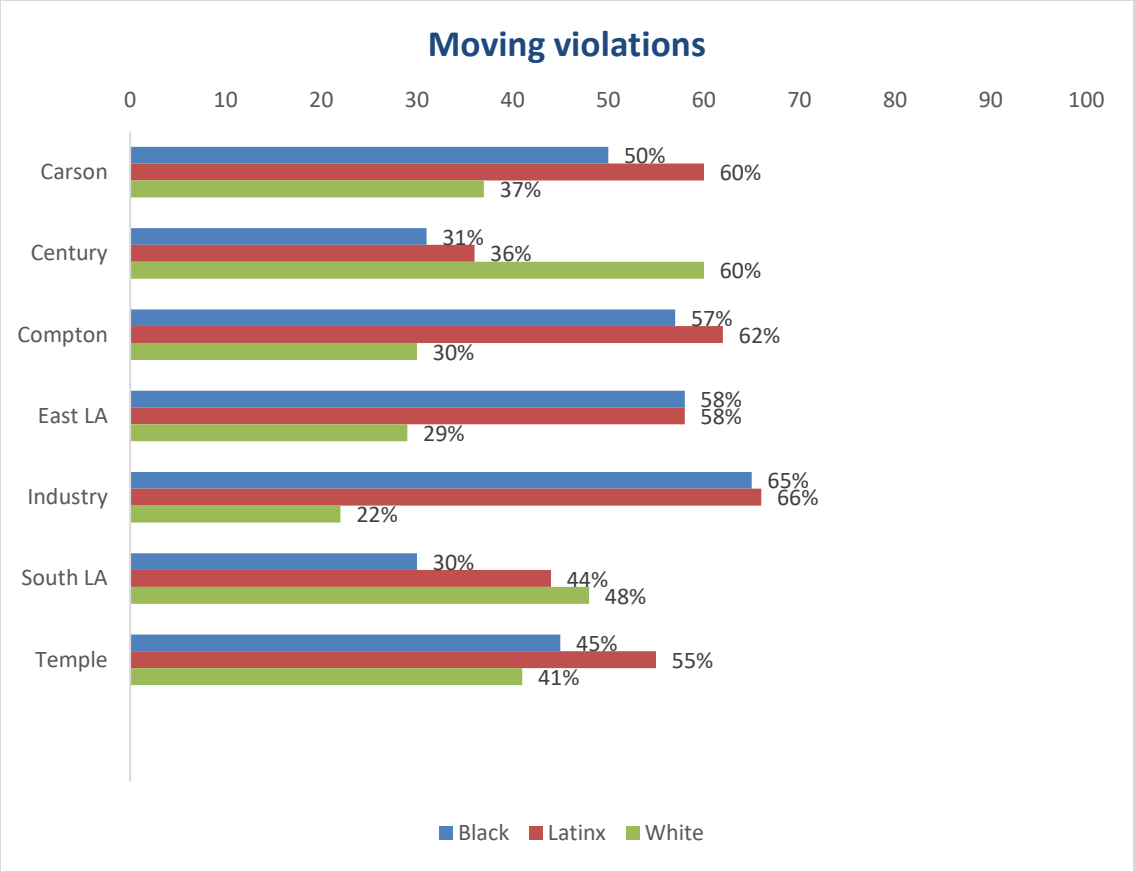
[56] *Id.*

[57] Lakewood is not shown in the charts for moving and non-moving violations because 17% of all stops were for non-moving violations and 83% were for moving violations, with little difference by race.

[58] *Id.*

Percentage of each group's stops for non-moving and moving violations 2019 – 2023





CPE recommended that the Sheriff's Department "deprioritize non-moving violation stops as dozens of other municipalities across the country have done."[59]

Non-moving stops led to more searches but did not turn up more contraband

Station	Discretionary search rate at non-moving violation stops	At moving violation stops	Contraband found at non-moving violation stops compared to moving
Carson	15%	5%	Slightly higher
Century	19%	16%	Lower
Compton	28%	9%	About the same
East LA	23%	7%	Same
Industry	16%	3%	About the same
Lakewood	11%	2%	About the same
South LA	31%	20%	Lower
Temple	13%	5%	Lower

[59] Center for Policing Equity, CPE Announces Release, *supra note 36*. This is consistent with the recommendations in OIG's report, *Addressing Racial Disparities in Traffic Stops* (Mar. 2023).

At every station, deputies conducted discretionary searches more often after non-moving violation stops than after moving violation stops. At Industry station, the rate was more than five times higher. Even so, these additional searches did result in the recovery of more contraband at any station except Carson, where the difference was small. At Century, South Los Angeles, and Temple stations, searches after non-moving violation stops found contraband less often.[60] Because Black and Latinx drivers are more likely to be stopped for non-moving violations, and those stops are more likely to lead to a search, this pattern likely contributes to the racial disparities in persons searched.

CPE explained:

> Non-Moving Violation stops are more likely to be pretextual, and more likely to result in a discretionary search. Police leaders often justify this by claiming such searches are necessary to get dangerous substances and weapons off the streets. If deputies do not discover significantly more contraband in searches that take place during Non-Moving Violation stops, it may suggest that the higher discretionary search rate at such stops is not justified and may be an inefficient use of police resources.[61]

Part 2: Discretionary Searches of Black, Latinx, and White Drivers

Once stopped, Latinx drivers were searched more often than White drivers at five stations, and Black drivers were searched more often at six.[62]

How often each group was searched after being stopped (compared to White drivers)

Station	Black drivers	Latinx drivers
Carson	Less often	About the same
Century	1.5 times as often	1.5 times as often
Compton	1.2 times as often	1.3 times as often
East LA	1.3 times as often	1.8 times as often
Industry	1.5 times as often	**2.2 times as often**
Lakewood	Less often	About the same
South LA	1.2 times as often	About the same
Temple	1.4 times as often	1.8 times as often

[60] Center for Policing Equity, *supra* note 51. This is consistent with the findings and recommendations in OIG's report, *Addressing Racial Disparities in Traffic Stops* (Mar. 2023).

[61] *Id.*

[62] *Id.*

Searches of Black and Latinx drivers did not find more contraband

At all eight stations, searches of Latinx drivers found contraband less often than searches of White drivers. The same was true for Black drivers at seven stations. East Los Angeles was the only exception, where searches of Black drivers found contraband more often than searches of White drivers.[63]

This matters because a common explanation for searching some groups more often is that they are more likely to possess something illegal. These results do not support that claim. When a group is searched more often but searches of that group find less contraband, according to CPE, it may indicate that deputies search those drivers at a lower level of suspicion.[64]

Most discretionary searches found no contraband

Station	Searches that found contraband	Searches that found firearms	How often consent and deputy safety searches found contraband
Carson	19%	1%	Consent 13%, Deputy Safety 16%
Century	17%	2%	Consent 7%, Deputy Safety 8%
Compton	27%	3%	Consent 12%, Deputy Safety 14%
East LA	23%	2%	Consent 12%, Deputy Safety 12%
Industry	19%	1%	Consent 10%, Deputy Safety 11%
Lakewood	20%	1%	Consent 11%, Deputy Safety 12%
South LA	36%	5%	Consent 13%, Deputy Safety 19%
Temple	21%	1%	Consent 16%, Deputy Safety 17%

Between 64% and 83% of discretionary searches found no contraband. When contraband was found, it was usually drugs, paraphernalia, or alcohol. Firearms were found in 5% or fewer searches at every station.[65]

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[63] *Id.*

[64] *Id.*

[65] *Id.*

Consent and deputy safety searches were the most common justification for searches at nearly every station. According to CPE, these searches generally require the lowest threshold of evidence of wrongdoing, and they found contraband only 7% to 19% of the time.[66]

Key Findings

1. At seven of eight stations, all except Lakewood, Black and Latinx drivers were more likely to be stopped for non-moving violations.
2. Non-moving violation stops led to more discretionary searches at every station, but not more contraband discovered. According to CPE, this may indicate inefficient use of Department resources.
3. Latinx drivers were searched more often than White drivers at five stations, reaching 2.2 times as often at Industry Station. Black drivers were searched more often at six stations.
4. Searches of Black and Latinx drivers found contraband less often than searches of White drivers at almost all stations. According to CPE, this pattern may indicate that deputies search Black and Latinx drivers at a lower level of suspicion threshold.
5. Consent and deputy safety searches were the most common justifications for discretionary searches and found contraband only 7% to 19% of the time.

Conclusion

CPE's analysis of the eight LASD patrol stations shows consistent racial disparities in how deputies stop and search drivers and, at two stations, pedestrians. At seven of the eight stations, Black drivers, and Latinx drivers stopped by deputies for nearly all of those stations, were more likely than White drivers to be stopped for non-moving violations, such as equipment and registration issues, that have little connection to road safety. These stops led to discretionary searches more often than moving violation stops, yet they did not produce more contraband discovery.

Once stopped, Black and Latinx drivers at most stations were searched more often than White drivers, and those searches were less likely to find contraband. Most discretionary searches at every station found no contraband, and firearms were found in 5% or fewer searches. Consent and deputy safety searches, which CPE notes generally

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[66] *Id.*

require the lowest threshold of evidence of wrongdoing, were the most common justifications for searches and among the least productive. Taken together, these findings suggest that current stop and search practices place a heavier burden on Black and Latinx drivers without a clear benefit to public safety while diverting LASD resources from more efficient uses.

OIG has issued numerous reports identifying racial disparities in the Sheriff's Department's interactions with the public. In April 2019, OIG published *The Los Angeles County Sheriff's Department's Santa Clarita Valley Domestic Highway Enforcement Team*, which reviewed the team's traffic stop data and found racial disparities in its stops. In December 2020, OIG published *Reform and Oversight Efforts: Los Angeles County Sheriff's Department*, recommending that the Department update its consent search policy, as the Los Angeles Police Department had done, by requiring deputies to document consensual searches and inform civilians of the search parameters before conducting them. In June 2022, OIG published *The Sheriff's Department's Underreporting of Civilian Stop Data to the California Attorney General*, which found that the Sheriff's Department was underreporting observation-based stops and arrests, and that stops of Latinx people were more likely to go unreported than stops of any other racial or ethnic group. That same month, OIG published *Allegations of Racial Disparities in Contacts with High School Students by the Sheriff's Department's Lancaster Station*, which reviewed data confirming reports that Black high school students in Lancaster were contacted, arrested, cited, suspended, and expelled at disproportionately higher rates than students of other racial groups. In March 2023, OIG published *Addressing Racial Disparities in Traffic Stops*, which recommended restricting crime suppression (pretextual stops) and adopting policies limiting non-moving violation stops.

The Racial and Identity Profiling Advisory (RIPA) Board's 2023 report, which analyzed 2021 data, found that the Sheriff's Department's total reportable stops (including vehicle, pedestrian, bicycle stops, and encounter that led to a search) increased 72.6% from 2020 to 2021.[67] The report also cited OIG's underreporting findings and warned that racial disparities at the Sheriff's Department may be larger than the data show.[68] Finally, the report cited the 2020 killing of Dijon Kizzee, whom LASD deputies shot 15 times after trying to stop him for riding his bike the wrong way, as an example of how pretextual stops can turn deadly.[69]

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[67] Racial and Identity Profiling Advisory Board, Annual Report 2023 (Jan. 1, 2023) p. 33, table 1.

[68] *Id.* at pp. at 34-35.

[69] *Id.* at p.61, fn. 171.

Recommendations for Minimizing Racial Disparities in Stops

1. **Reduce stops for non-moving violations.** The Sheriff's Department should evaluate whether stops for equipment and registration issues serve a public safety purpose. Where they do not, the Department should consider alternatives such as warnings by mail or fix-it notices and focus deputy time on moving violations that affect road safety.
2. **Limit consent and deputy safety searches.** The Sheriff's Department should consider requiring reasonable, articulable suspicion before a deputy asks for consent to search and should review whether deputy safety searches are supported by specific, documented facts.
3. **Conduct station-level reviews where disparities are greatest.** Industry, Temple, East Los Angeles, and Century Stations showed the largest gaps in search rates between Latinx or Black drivers and White drivers. The Department should examine the practices, supervision, and deployment decisions behind those gaps.
4. **Consider adopting the recommendations in OIG's report, *Addressing Racial Disparities in Traffic Stops*.** OIG continues to recommend that the Department implement OIG's recommendations on traffic stops and consent searches.

Status of Labor Negotiations on Measure R and AB 847

With the passage of Measure R and AB 847 both OIG and the COC have the power to subpoena documents and the legal right to access and review peace officer and custodial officer records. Legal actions initiated in 2022, 2023, and 2025, by the two labor unions representing sworn peace officers, the Association for Los Angeles Deputy Sheriff's (ALADS) and the Los Angeles County Professional Peace Officers Association (PPOA), resulted in binding decisions that the County must negotiate with the labor unions over the ***effects*** of the laws that granted this power and access to these records.[70] To date, OIG staff and COC staff have attended negotiation sessions to which an invitation to participate was extended.

[70] The court decisions note that only effects bargaining is necessary, meaning the policy implementation consistent with the laws is permissible. The Sheriff's Department routinely bargains over the policy implementation rather than implementing the policy as a management decision and then bargaining only on the effects.

Measure R was passed in 2020. The most recent negotiating session, commonly referred to as the meet and confer process, for Measure R was July 31, 2025.[71]

AB 847, codified in Government Code section 25303.7 and Penal Code section 832.7, was passed in 2025 and became effective January 1, 2026. To date, the County has met with PPOA and ALADS once each; the meet and confer session with PPOA was on March 2, 2026, and the meet and confer session with ALADS was on March 23, 2026.

The Office of Inspector General inquired as to whether future meet and confer sessions are scheduled; recently the County's CEO Employee Relations division reached out to OIG stating it has taken a more prominent role and is working to schedule a meeting to discuss next steps .[72] Because of the newly released policy prohibiting deputy clique participation, OIG also inquired as to whether the language in the policy covers some of the conditions of employment.[73]

CUSTODY DIVISION

Jail Monitoring and Inspections

The Office of Inspector General regularly conducts site visits and inspections at Sheriff's Department custodial facilities. In the third quarter of 2026, Office of Inspector General personnel conducted site visits at Inmate Reception Center (IRC), Twin Towers Correctional Facility (TTCF), Century Regional Detention Facility (CRDF), Men's Central Jail (MCJ), Pitchess Detention Center-North (PDC-North), Pitchess Detention Center-South (PDC-South), Pitchess Detention Center-East (PDC-East), North County Correctional Facility (NCCF), Cerritos Station, Carson Station, San Dimas Station, Walnut/Diamond Bar Station, Century Station, Crescenta Valley Station, and West Hollywood Station.

As part of the Office of Inspector General's jail monitoring, Office of Inspector General staff attended Custody Services Division (CSD) executive and administrative meetings

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[71] The County and the labor unions have exchanged emails after this date but there have not been any meetings.

[72] Emails inquiring whether OIG executive staff would continue to participate in negotiations and the status of ongoing negotiations were sent to County Counsel on September 24, 2026, and October 22, 2026.

[73] MPP 3-01/050.83 - *Prohibited Cliques: Employee Groups Which Violate Rights of Other Employees or Members of the Public*, states in part: "the Department shall cooperate with the Office of the Inspector General, the California Attorney General, and/or any other authorized agency investigating the existence or the potential existence of such organizations within the Department. Employees are required as a condition of employment to participate in these investigations, answer questions, and do so honestly."

and met with division executives about uses of force, in-custody deaths, PREA compliance, restrictive housing, and general conditions of confinement. Office of Inspector General staff also reviewed documentation in custody databases, data and documentation provided by the Department, body-worn camera video of critical incidents, and CCTV video of jail operations at TTCF, CRDF, MCJ, PDC-North, PDC-South, and NCCF.

Jail Overcrowding

As previously reported by the Office of Inspector General, overcrowding in certain Los Angeles County jail facilities continues to jeopardize the ability of the Sheriff's Department to provide habitable, humane, and safe conditions of confinement as required by the Eighth and Fourteenth Amendments to the U.S. Constitution.[74]

The Los Angeles County jails have a Board of State and Community Corrections (BSCC) total rated capacity of 12,404.[75] According to the Sheriff's Department's Population Management Bureau Daily Inmate Statistics, the total population of people in custody in the Los Angeles County jail facilities was 11,902 as of June 30, 2026, and 11,794 as of September 30, 2026.

The table below shows the daily count of people in custody, according to the Population Management Bureau Daily Inmate Statistics, at MCJ, TTCF, CRDF, PDC-East, PDC-North, PDC-South, and NCCF on the last day of the previous four quarters.

On these dates, three facilities (MCJ, PDC-North, and NCCF) that together account for more than half the Department's jail capacity operated over the BSCC rated capacity.

Facility	BSCC Capacity	Facility Count			
		12/31/2025	3/31/2026	6/30/2026	9/30/2026
MCJ	3512	3609	3812	3668	3549
TTCF	2432	2309	2270	2177	2169

[74] See *Fischer v. Winter* (1983) 564 F. Supp. 281, 299 (noting that while overcrowding may not be unconstitutional in itself, overcrowding is a root cause of deficiencies in basic living conditions, such as providing sufficient shelter, clothing, food, medical care, sanitation, and personal safety).

[75] The total rated capacity is arrived at by adding the rated capacity for each of the County jail facilities: MCJ 3512, TTCF 2432, CRDF 1708, PDC-East 926, PDC-North 830, PDC-South 782, and NCCF 2214. Some portions of the jail facilities are not included in the BSCC capacity ratings. When referring to the jail facilities, this report includes only the BSCC rated facilities. The rated capacity has not been recently updated and does not take into account the pandemic, understaffing, or the deteriorating physical plant of MCJ, meaning that the current safe capacity of the Los Angeles County jails is certainly substantially lower than the rated maximum.

CRDF	1708	1414	1430	1293	1277
PDC-East	926	11	15	13	35
PDC-North	830	1321	1253	1286	1277
PDC-South	782	611	640	613	620
NCCF	2214	2961	3042	2852	2867

Availability of Menstrual Products in the Los Angeles County Jails

On June 25, 2024, the Board of Supervisors (Board) passed a motion directing the Office of Inspector General report back quarterly on policies related to the availability and accessibility of menstrual products in the Los Angeles County jails, in light of recent legislation.[76]

Between July and September 2026, Office of Inspector General staff periodically verified the availability and accessibility of menstrual products at CRDF during site visits.[77] Previously reported concerns about menstrual product accessibility and distribution persist, particularly in high observation housing (HOH) and restrictive housing modules, where access depends largely on the discretion of custody staff and incarcerated workers.[78] Although many people in these units reported generally receiving products upon request, others described inconsistent access, and some appeared unable to respond to questions about access because of their mental health condition. Requiring people in HOH to request products may leave those with the most severe mental health conditions without access, as they may be unable to advocate for

[76] See Penal Code, § 4023.5(a). ("A person confined in a local detention facility shall be allowed to continue to use materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the incarcerated person."); Cal. Code Regs., tit 15, § 1265. (Each menstruating person shall be provided with sanitary napkins, panty liners, and tampons as requested with no maximum allowance."); Los Angeles County Sheriff's Department, Custody Division Manual, CDM 6-15/010.00 *Inmate Clothing, Bedding, and Personal Hygiene*. ("All menstruating inmates shall have ready access to sanitary napkins, panty liners, and tampons."); Los Angeles County Sheriff's Department, Custody Division Unit Order, CDM 5-16-040 *Distribution of Personal Care Items*. ("Each menstruating inmate housed at CRDF shall be provided with sanitary napkins, panty liners, and tampons. All feminine hygiene products shall be readily available in a common space within each module or pod setting."); Penal Code, § 3409(a). ("A person incarcerated…who menstruates or experiences uterine or vaginal bleeding shall, without needing to request, have ready access to, and be allowed to use, materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the person.").

[77] During this reporting period, staff from the Office of Inspector General visited general population, Forensic In-Patient (FIP) Stepdown, high observation housing (HOH), moderate observation housing (MOH), restrictive, and medical housing, as well as the working dorm, medical intake and reception center.

[78] People held in these units lack access to common areas for most of the day and may remain handcuffed even when permitted.

themselves or request products when needed. These barriers reinforce the need to supplement products available in common areas with cell-to-cell distribution. Such distribution must comply with any individual limitations on menstrual products.

In its first quarterly report of 2025, the Office of Inspector General reported on the availability and accessibility of menstrual products for individuals in HOH, including those on suicide watch. With input from Correctional Health Services (CHS), CRDF leadership at the time decided to purchase suicide prevention jumpsuits with a middle lining that would allow menstruating people under suicide precautions to affix pads to the jumpsuit. Following procurement, the facility planned to pilot the distribution of the jumpsuits to evaluate their use prior to full implementation and before developing or updating existing policy.

Leadership transitions at CRDF and fiscal and logistical setbacks have contributed to delays in purchasing and piloting the jumpsuits. During this reporting period, current facility leadership reported ordering one suicide prevention jumpsuit from PSP Corp USA to assess its durability and safety.[79] The $400 jumpsuit is designed to preserve privacy and dignity while offering the same anti-ligature and fire-retardant safety as standard suicide prevention gowns. After evaluating the product, CRDF will order additional jumpsuits for the pilot. Facility leadership identified the pilot as a high priority and committed to advancing it in 2027.

Recommendation for the Sheriff's Department

In response to the Board's motion, the Office of Inspector General recommends that CRDF collaborate with CHS to develop a policy ensuring menstrual products are accessible to individuals with mental health needs. The policy should address the additional support that individuals with serious mental health conditions may need to manage their menstrual care.

Commissary Prices

Background

On July 9, 2024, the Board of Supervisors passed a motion directing Office of Inspector General to provide quarterly updates on the Department's progress on the removal of profit mark-ups and implementation of price reductions on commissary items.

[79] Laundry Services will test the jumpsuit's durability through repeated laundering, and CHS and DMH will assess its safety and suitability for the intended population.

The Department has not made any changes to commissary prices since the Office of Inspector General last reported.

Kosher and Halal Menu Availability

In its *Reform and Oversight Efforts: Los Angeles County Sheriff's Department – July through September 2025* report, the Office of Inspector General discussed the availability of updated Kosher and Halal menus. The contract change order for the new menu was finalized and facilities are working to distribute updated menus with Kosher and Halal identifiers to people in custody at all of the jail facilities.

Use of Restraints on Pregnant People in Custody

In the OIG's report on reform and oversight for last quarter, the Sheriff's Department reported a proposed change in its policy on using restraints on people in labor, delivery, or recovery that would lower the standard for allowing restraints. Under the past standard, as noted in OIG's report, restraints were permitted if the person posed an immediate threat of great bodily injury or death to themselves, the fetus, or others.[80] Despite OIG's recommendation not to change the standard, the Sheriff's Department is proceeding with the revision, which would allow restraints on people in custody in labor, delivery, or recovery if "deemed necessary for the safety and security of the inmate, the staff, or the public."[81]

In-Custody Deaths

Between July 1 and September 30, 2026, nine people died in the care and custody of the Sheriff's Department. The Department of Medical Examiner's (DME) website currently reflects the manner of death for three of these deaths: two natural and one homicide. [82] Six people died at MCJ, one person died at PDC-South, one person died at

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[80] OIG does not know when the revised policy will take effect but uses the past tense here because of the Department's stated intention to adopt the lower standard.

[81] While California Penal Code § 3407(b) allows for the use of restraints in accordance with the Sheriff's Department policy, the more restrictive policy is a better practice.

[82] In the past, the Office of Inspector General has reported on the preliminary cause of death as determined by the Medical Examiner, Correctional Health Services (CHS) personnel, hospital personnel providing care at the time of death, and/or Sheriff's Department Homicide investigators. Because the information provided is preliminary, the

TTCF, and one person died at the hospital after being transported from the jail. The Department posts the information regarding in-custody deaths on a dedicated page on Inmate In-Custody Deaths on its website.[83]

Office of Inspector General staff attended the Custody Services Division Administrative Death Reviews and the CHS Mortality Reviews for each of the nine in-custody deaths. The following summaries, arranged in chronological order, provide brief descriptions of each in-custody death:

Date of Death: July 17, 2026
Custodial Status: Sentenced
On July 17, 2026, custody staff observed that something was "not right" in a multi-person cell at MCJ during a Title 15 safety check. After reviewing CCTV video, custody staff returned to the cell to conduct a welfare check and discovered an unresponsive person covered in blood. Custody staff, CHS staff, and paramedics rendered emergency aid but did not administer Narcan. The person died at the scene. Preliminary manner of death: Homicide. The DME website reflects the manner of death as homicide and the cause of death as multiple sharp force injuries.

Areas of Inquiry: Management of housing classifications, population control, adequacy of wristband counts, the quality of Title 15 safety checks, monitoring CCTV for safety concerns, housing people in custody with differing security level classifications in close proximity to each other at MCJ, custody staff's supervision of module operations involving movement of people in custody, and custody staff's failure to administer Narcan.[84]

Office of Inspector General has determined that the better practice is to report on the manner of death. There are five manner of death classifications: natural, accident, suicide, homicide, and undetermined. Natural causes can include illnesses and disease and thus deaths due to COVID-19 are classified as natural. Overdoses may be accidental, or the result of a purposeful ingestion. The Sheriff's Department and CHS use evidence gathered during the investigation to make a preliminary determination as to whether an overdose is accidental or purposeful. Where the suspected cause of death is reported by the Sheriff's Department and CHS, the Office of Inspector General will include this in parenthesis.

[83] Penal Code § 10008 requires that within 10 days of any death of a person in custody at a local correctional facility, the facility must post on its website information about the death, including the manner and means of death, and must update the posting within 30 days of a change in the information.

[84] While the death does not appear to be related to the ingestion of narcotics, Narcan should be administered during medical emergencies.

Date of Death: July 28, 2026

Custodial Status: Pre-trial

On July 28, 2026, a person in custody housed at PDC-North experienced a medical emergency while being transported to court on a Court Services Transportation (CST) bus. After other people in custody on the bus alerted CST staff to a “man down,” staff drove the bus to a secure location at nearby PDC-South and requested medical personnel and paramedics. Custody staff removed the person from the bus, and custody staff, CHS staff, and paramedics rendered emergency aid, and administered Narcan. The person died at the scene. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural and the cause of death as atherosclerotic cardiovascular disease.

Areas of Inquiry: The lack of Narcan on CST buses, the availability of alternative needle-free Narcan nasal spray, and failure to document facility contraband searches at PDC-North.

Date of Death: August 12, 2026

Custodial Status: Sentenced

On August 12, 2026, people in custody in a multi-person cell at MCJ alerted custody staff of a “man down.” Custody staff, CHS staff, and paramedics rendered emergency aid, and administered Narcan. The person died at the scene. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural and the cause of death as hypertensive cardiovascular disease.

Areas of Inquiry: Custody staff’s administration of emergency aid, the operability of CCTV cameras, the quality of Title 15 safety checks, custody staff’s failure to activate their body-worn cameras, missed and rescheduled medical appointments, the unavailability of custody staff to escort the person to a medical appointment, and CHS protocols for safely engaging with people in custody while providing medical care.

Date of Death: August 30, 2026

Custodial Status: Pre-trial

On August 30, 2026, custody staff conducting Title 15 safety checks at MCJ found two unresponsive people in a two-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid and administered Narcan. One person was transported to Los Angeles General Medical Center (LAGMC) and one person died at the scene. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Areas of Inquiry: The quality and timeliness of Title 15 safety checks and of the request for Los Angeles County Fire Department paramedics, timeliness of custody staff's activation of their body-worn cameras, CHS staff's failure to conduct medical testing, and CHS staff's adherence to medication distribution practices.

Date of Death: September 2, 2026
Custodial Status: Pre-trial
On September 2, 2026, people in custody in a dorm at MCJ alerted custody staff of a "man down." Custody staff, CHS staff, and paramedics rendered emergency aid, and administered Narcan. The person died at the scene. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Areas of inquiry: The quality of Title 15 safety checks, implementation of processes to effectively scan legal mail for narcotics, mail distribution policies and practices to prevent narcotics distribution, and the implementation of policies and practices to prevent narcotics from entering the facility.

Date of Death: September 5, 2026
Custodial Status: Pre-trial
On August 25, 2026, custody and CHS staff discovered an unresponsive person while conducting a welfare check at TTCF-Correctional Treatment Center (CTC). Custody staff requested paramedics while CHS staff initiated cardiopulmonary resuscitation (CPR) and administered Narcan. Paramedics took over resuscitative efforts and LAGMC for a higher level of care. The person died on September 5, 2026. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Areas of Inquiry: The quality and timeliness of Title 15 safety checks and the collaboration between custody staff and CHS in administering emergency aid.

Date of Death: September 11, 2026
Custodial Status: Pre-trial
On September 11, 2026, custody staff conducting Title 15 safety checks at MCJ discovered an unresponsive person in a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid and administered Narcan. The person died at the scene. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Areas of Inquiry: The quality of Title 15 safety checks, the exigency of custody staff's emergency response, and protocols regarding expectations of custody staff when encountering people in custody roaming outside their assigned housing locations.

Date of Death: September 20, 2026
Custodial Status: Pre-trial
On September 20, 2026, custody staff conducting Title 15 safety checks at TTCF found an unconscious person in a two-person cell. Custody staff, CHS staff, and paramedics rendered aid, and administered Narcan. The person died at the scene. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Areas of inquiry: The quality and timeliness of Title 15 safety checks, positioning of CCTV cameras within TTCF module, custody staff's delay in rendering emergency aid, ensuring newly hired staff are scheduled to work alongside experienced custody staff, and moving the person before administering emergency aid.

Date of Death: September 21, 2026
Custodial Status: Pre-trial
On September 21, 2026, people in custody in a dorm at MCJ alerted custody staff of a "man down." Custody staff, CHS staff, and paramedics rendered aid and CHS administered Narcan. The person died at the scene. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Areas of inquiry: The exigency of custody staff's emergency response, custody staff's failure to administer Narcan, custody staff leaving the facility prior to being interviewed by the Department's Homicide Bureau detectives, and the approximately five-minute delay in custody staff responding to the "man down" alert.

Efforts to Reduce In-Custody Deaths

On March 3, 2026, the Board of supervisors passed a motion titled *Strengthening Accountability to Significantly Decrease Jail Deaths in the Los Angeles County Jails*. The motion directs the Office of Inspector General to include in its quarterly reporting information on the Medication Assisted Treatment program, summaries and status of corrective action plans (CAPs) instituted after an in-custody death, improvements to the CAP tracker, compassionate release efforts, and an analysis of the Mortality Review process. The Office of Inspector General since monitored and tracked these items, by continuing to attend each administrative death review and mortality review, meeting with CHS and Custody Division executive staff, and reviewing Corrective Action Plan (CAP)

data provided by Custody Division Custody Compliance and Sustainability Bureau (CCSB).

Correctional Health Services Compassionate Release Efforts

The Board's motion directed CHS to "identify ways…to expedite compassionate releases" with consideration to California Penal Code section1172.2.

Penal Code section 1172.2 provides that the California Department of Corrections and Rehabilitation (CDCR) may recommend recalling the sentence of a person in custody who has a "serious and advanced illness with an end-of life trajectory" or is "permanently medically incapacitated with a medical condition or functional impairment that renders them permanently unable to complete basic activities of daily living."

The legal standard governing compassionate release from local detention facilities is narrower than the standard established by Penal Code section 1172.2. California Government Code sections 26605.5 and 26605.6 authorizes the Sheriff to compassionately release a person in county custody who no longer poses a threat to the safety of others and who is either so severely physically incapacitated or has a life expectancy of less than six months.

Recognizing these limits, the CHS Chief Medical Officer developed an alternative protocol to petition the courts to release people in custody based on their medical conditions. The Chief Medical Officer reported that CHS providers regularly send letters requesting release on behalf of people in custody with significant medical conditions to the court, defense attorney, and prosecutor assigned to each person's criminal case. From January 1 to September 30, 2026, CHS submitted 52 such letters. Of these, 25 requests were granted, 4 were denied, 13 remain pending. The remaining 10 became unnecessary because the person was released for reasons unrelated to their medical condition or died.

Summaries of In-Custody Death Corrective Action Plans

Second Quarter of 2026

An in-custody death may result in the Sheriff's Department opening multiple CAPs. The Department's CCSB provided the Office of Inspector General data regarding CAPs opened between January 1, 2021, and September 30, 2026.

A total of 751 CAPs were opened between January 1, 2021, and September 30, 2026. Of these CAPs, 663 have been completed and 88 remain outstanding.

The tables on the following pages show the number of outstanding CAPs opened by year and the number of outstanding CAPs opened by year and facility.

Outstanding CAPs by Year Opened		
Year	**CAPs Opened**	**CAPs Outstanding**
2021	152	0
2022	145	5
2023	128	6
2024	107	22
2025	134	27
2026	85	28
TOTAL	751	88

Outstanding CAPs Opened Each Year by Facility						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
MCJ	0	4	6	18	15	17
TTCF	0	0	0	0	6	7
IRC	0	0	0	0	0	0
CRDF	0	0	0	0	0	0
NCCF	0	0	0	0	0	0
PDC-North	0	0	0	0	0	0
PDC-South	0	0	0	0	0	0

PDC-East	0	0	0	0	0	0
Station Jails	0	0	0	0	5	0
Other Units	0	1	0	4	1	4
TOTAL	0	5	6	22	27	28

CAPs can address a variety of issues identified after an in-custody death, as described in the *In-Custody Death* sections of Office of Inspector General quarterly reports. However, most CAPs pertain to the quality and/or timeliness of Title 15 safety checks and the emergency response rendered when finding an unresponsive person in custody. The table below shows the number of outstanding CAPs opened by year and category.

Outstanding CAPs Opened Each Year by Category[85]

	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Title 15 Safety Checks	0	2	1	5	6	5
Emergency Response	0	1	3	5	7	6
Wristband Count	0	0	1	2	0	1
CCTV /BWC	0	0	0	0	3	5
Searches / Contraband	0	0	0	2	3	0

[85] Because CAPs can involve a variety of issues, CCSB consolidated CAP categories when providing this data to the Office of Inspector General. Title 15 safety checks includes concerns with the quality and/or timeliness of Title 15 Safety Checks, emergency response includes custody staff's rendering of emergency aid upon finding an unresponsive person, custody procedural includes custody division manual policies or jail operation procedures, CCTV includes issues concerning the functionality of jail closed-circuit television, searches/contraband includes issues concerning contraband detection, and other categories includes issues not counted in the aforementioned categories.

Other Categories	0	2	1	8	8	11
TOTAL	0	5	6	22	27	28

Each CAP may require multiple proofs of practice. For example, a CAP item regarding Title 15 safety checks may require several proofs of practice, such as a memorandum, a supervisory inquiry, a training roster, or a briefing. During the period covered by this report, 751 CAPs generated 1,989 proofs of practice.

Outstanding CAPs Opened Each Year by Outstanding Proof of Practice[86]						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Briefing	0	1	2	4	16	2
Training	0	0	1	3	1	6
Administrative Investigations	0	0	0	0	0	4
Performance Log Entry	0	0	0	0	1	3
Policy Review / Established / Revised	0	0	0	1	2	1
Memorandum	0	4	6	20	19	25
Other Proof of Practice	0	0	2	5	7	22
TOTAL	0	5	11	33	46	63

In-Custody Overdose Deaths in Los Angeles County Jails

On December 19, 2023, the Board of Supervisors passed a motion directing the Sheriff's Department to "[c]ollect and track data outlining narcotics recovery in county jail facilities to evaluate the efficacy of drug detection interventions and provide information to the OIG," and [s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the facility, beyond visual inspections" and directed the Office of Inspector General to report quarterly on the Department's progress on these mandates.

[86] Proof of Practice is the evidence that must be provided to CSSB to prove that a CAP was completed and closed.

Of the nine people who died in the care and custody of the Sheriff's Department between July 1 and September 30, 2026, the medical examiner's final reports, including toxicology assessments, do not confirm that any person died due to an accidental overdose. As of this report, the DME has confirmed that two individuals died due to accidental overdose during the first three quarters of calendar year 2026.

Tracking and Improving Narcotics Intervention Efforts

As previously reported, the Sheriff's Department does not presently track narcotics detection in a format that allows data to be analyzed and reports that it does not have the capacity to build a mechanism to track narcotics seizures by drug detection mechanism, nor is it able to compile extractable data collected in the Los Angeles Regional Crime Information System (LARCIS) to evaluate the efficacy of drug detection intervention. Instead, the Department takes the position that constructing an all-encompassing jail management data system would best support the Department's efforts to track narcotics recovery and evaluate the efficacy of drug detection interventions. The Office of Inspector General continues to recommend that the Department examine ways to comply with the Board's directive by standardizing search procedures division-wide, improving reporting requirements for staff, and compiling data on detection interventions and seizures using existing technologies.

The Board's second directive requires that the Sheriff's Department "[s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the [jails]." The Department previously reported that its current policy grants the Department broad authority to search staff and civilians entering jails, so that no changes to existing policy are required to implement more comprehensive searches.

Staff Searches

To review the quality of staff searches, the Office of Inspector General requested detailed search data from CSSB, which allowed the Office of Inspector General to review closed-circuit television (CCTV) video of search operations.[87] However, the data provided by the Custody Investigative Services Unit (CISU)-Custody Canine Detail (CISU-Canine Unit) did not include the dates and times of canine-assisted staff

[87] CSSB provides monthly search data to the Office of Inspector General as directed by the 2023 Board motion.

searches, so the Office of Inspector General was unable to specifically select any of those searches for review.[88]

The Office of Inspector General's review showed that, during the dates and times that CSSB indicated that facilities conducted staff searches, the majority of the people entering the jail were not searched and, in some instances, a search was never conducted despite CSSB data indicating otherwise.

The Office of Inspector General reviewed 18 staff searches via CCTV, one of which happened to involve the CISU-Canine Unit. The searches reviewed were conducted at CRDF, MCJ, TTCF, PDC-North, and PDC-South.

Office of Inspector General staff were unable to review staff searches at PDC-North due to the facility not having a designated fixed point for staff searches because of the facility's layout and blurred distinction between secured and non-secured areas. Office of Inspector General staff reviewed CCTV of the area which PDC-South facility leadership designated as the staff search area on the dates and times CSSB provided but did not observe any staff searches taking place.

For all remaining facilities, Office of Inspector General Staff observed two supervising deputies sitting at a table, sworn staff entering the jails, writing on a preprinted paper on the table, and walking past the two supervising deputies into the secured area.[89] The majority of the people, sworn or non-sworn, entering the facility were not searched at all, including people carrying bags or backpacks that were not transparent, in violation of

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[88] MPP 5-09/265.15 – *Scent Detection Canine Deployment* details each of the Department's canine units. The CISU Canine Detail is detailed as follows:

Custody canine deployment is specialized and unique in its function. This type of deployment involves criteria for canine selection, canine training, and canine certification for the purposes of searching people. Due to this specialization and unique criteria, the CISU - Custody Canine Detail will use canine vendors willing to be insured to enter and train within custody facilities for the purposes of searching persons. Custody canines will continue to train on "passive alerts" (sit-and-turn-away) to alleviate the potential for complaints. Custody canines will be required to certify with certifying entities which include standards for people sniffs. The use of canines to search for other odors may be directed by the assistant sheriff of Custody Services Division or his or her designee. All personnel assigned to the Custody Canine Detail will adhere to the guidelines of the CISU - Custody Canine Detail unit orders.

[89] Searches at TTCF are conducted inside the secured area.

Department policy.[90] Supervisors visually inspected staff's property only in a few instances. During these searches, the Office of Inspector General observed supervisors peek inside bags for one to two seconds prior to allowing staff to enter the facility.

The search involving the CISU-Canine Unit was more comprehensive. The CISU-Canine Unit dog appeared to be searching the entire time it was deployed by actively walking around and near people entering and exiting the jail. Although the dog did not appear to detect any contraband during the search, it was the only active search of people entering the jail.

CISU-Canine Unit

The Office of Inspector General met with Department staff to discuss its CISU-Canine Unit. The CISU-Canine Unit currently has 18 dogs in service and 9 senior deputies as handlers and provides support to the Department's custody and patrol divisions.[91] Department staff reported the CISU-Canine Unit needs more resources, including handlers, dogs, and vehicles with kennel systems to safely transport canines.[92]

The CISU-Canine Unit staff explained that canine training consists of repetition and reward. Dogs are trained to detect the scents of different types of contraband and are rewarded every time they accurately hit a target. It takes roughly 200 to 500 repetitions before a dog is prepared for duty. Once trained, some dogs actively scan for scents, without the handler's command to search, to receive a reward. Dogs are able to work for approximately one hour before needing one to two hours of rest.

Department staff reported that dogs are effective in detecting contraband concealed in mail and body cavities and may be more effective than the Department's mail and body scanners. The Department has reported that mail scanners are deficient in detecting all narcotics contained in mail. The Department's body scanners require that staff have a high level of expertise to interpret whether body scans indicate a potential presence of contraband. If custody staff are not properly trained or regularly assigned to work body

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[90] Custody Division Manual, Vol. 3 Administrative Policy and Procedure, 3-01/090.00 *Personnel Screening Procedures and Allowable Property* (see subheading "Personal Bags").

[91] Similar to how supervisors are responsible for conducting facility staff searches, the CISU-Canine Unit tasks senior deputies to deploy the canines during searches.

[92] The Department reported that most of the CISU-Canine Unit vehicles are old and are often in need of repair, which removes them from service.

scanners and interpret anomalies in scanned objects, the machine's superior features are rendered useless.

Increasing resources to the CISU-Canine Unit could aid in contraband detection by preventing the introduction of contraband into the facilities and in finding contraband already in the jails. Dogs can be used to detect contraband in housing locations, on people in custody, on staff, secreted in body cavities, and in the mail. The CISU-Canine Unit's versatility could prove more effective in eliminating contraband from the jails than other search methods.

Recommendations for Contraband Detection to Prevent Overdose Deaths

1. The Office of Inspector General recommends that the Department explore expanding the CISU- Canine Unit.
2. The Office of Inspector General continues to recommend that the Department adopt the proposals reported in *Reform and Oversight Efforts: Los Angeles Sheriff's Department July through September 2025 Report*:

    a. establish a single point of entry and exit at jail facilities,
    b. restrict allowable personal property,
    c. monitor traffic in the transportation compound and
    d. enhance security and monitoring.

Sheriff's Department Search Statistics

As previously reported, the comprehensiveness of the searches varies across facilities as does the minimum requirement per week. The table on the following page details the staff search practices at all custodial facilities from July 1 to September 30, 2026. The data regarding the number of staff searches and searches with K-9 illustrated in the table was supplied by Custody Support Services Bureau (CSSB). CSSB extracted data on searches from the Custody Watch Commander's Log (CWCL) on October 7, 2026. K-9 data was obtained from the Custody Investigative Services (CIS) K-9 Detail Facility Checkpoint Report on October 8, 2026. The Office of Inspector General was unable to verify the data provided by CSSB without additional information:

Facility	Number of Staff Searches Q3	Number of Staff Searches with K-9 Q3	Monthly Minimum Search Requirement[93]	Search Inside Security	Search Evasion Concerns	Where Searches Logged
MCJ	150	24	Unable to Determine[94]	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
TTCF	195	9	Yes[95]	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
IRC	61	3	Unable to Determine[96]	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
CRDF	108	7	Yes[97]	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
NCCF	148	9	No[98]	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report

[93] Each jail facility's unit order regarding staff searches was used to determine whether it met its minimum search requirement by month. Where the unit order is silent regarding the minimum search requirement, the Office of Inspector General was unable to determine if the requirement was met. Also, the jail facility must meet the minimum search requirement during each of the three months in the quarter in order to be found in compliance.

[94] Los Angeles County Sheriff's Department, Men's Central Jail Unit Orders, § 3-08-021 *Security of Personal Property* does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

[95] Los Angeles County Sheriff's Department, Twin Towers Correctional Facility Unit Orders, § 3-08-010 *Security of Personal Property*. ("Watch commander shall ensure a minimum of two random searches are conducted each week of persons entering the secured area during their assigned shift").

[96] Los Angeles County Sheriff's Department, IRC Unit Order, § 5-23/006.00 *Security and Searches of Person Property* does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

[97] Los Angeles County Sheriff's Department, CRDF Unit Orders, § 3-01-090 *Searches of Sworn Personnel, Custody Assistants, Professional Staff and their personal property* - Approved by CSSB 3/11/2024 ("The searches shall be conducted a minimum of once per week, per shift." [unit order obtained via email message]).

[98] NCCF did not meet its minimum search requirement in September 2026. Los Angeles County Sheriff's Department, Custody Division Unit Order, § 07-145/10 *Personal Property Searches*. ("A minimum of four (4) random searches per shift per week of any personnel and/or official visitors shall be conducted at the discretion of the watch sergeant.").

PDC-North	57	4	Unable to Determine[99]	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
PDC-South	76	8	Yes[100]	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report

Medication Assisted Treatment

On March 3, 2026, the Board of Supervisors passed a revised motion aimed at decreasing jail deaths in custody, particularly drug-related deaths, through overdose prevention efforts. The motion requires that the Office of Inspector General include information on the Medication Assisted Treatment (MAT) program in its quarterly reports. CHS is required to provide the Office of Inspector General with data, including the number of incarcerated individuals on the waitlist, the number of unique participants receiving treatment at each custodial facility, and the types of medications being administered, such as oral medications or long-acting injectable (LAI) formulations. CHS provided the Office of Inspector General with the data below.

Count of patients waiting for LAI per their request:

Facility	July 13		August 5		September 5	
	Female	Male	Female	Male	Female	Male
CRDF	0	0	0	0	0	0
IRC	0	0	0	0	0	0
MCJ	0	15	0	10	0	0
NCCF	0	0	0	0	0	0
PDC	0	9	0	6	0	0
TTCF Tower I	0	3	0	1	0	0
TTCF Tower II	0	3	0	1	0	0

Individuals receiving *oral* MAT per facility on the 5th of each month:

Facility	July 5	August 5	September 5
CRDF	52	29	20
IRC	197	24	24

[99] Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-06-010 *Security of Personal Property* does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

[100] Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-02-080 *Searches of Sworn Personnel, Custody Assistants, Professional Staff and Their Property on the Facility*. ("The searches shall be conducted at a minimum of once per week, per shift.").

MCJ	128	104	74
NCCF	0	0	0
PDC	70	39	34
TTCF Tower I	37	9	15
TTCF Tower II	35	16	9
TTCF CTC	4	3	3

Individuals receiving *LAI* MAT per facility on the 5th of each month:

Facility	July 5	August 5	September 5
CRDF	131	113	127
IRC	388	7	1
MCJ	486	616	650
NCCF	0	0	0
PDC	419	564	600
TTCF Tower I	120	133	139
TTCF Tower II	81	84	95
TTCF CTC	15	8	5

Number of individuals receiving MAT (oral or LAI) per facility each month by gender:

Treatment Type	July 13		August 5		September 5	
	Female	Male	Female	Male	Female	Male
LAI	135	1620	166	1711	150	1631
Oral	153	1354	141	984	117	922

Total number of injections provided by gender July 2026-September 2026.

Gender	LAI Doses
Female	483
Male	5324
Total	5807

Accessibility of Naloxone in Custodial Facilities

The motion also directed the Office of Inspector General to collaborate with the COC and the Sybil Brand Commission for Institutional Inspections (SBC) to monitor the accessibility and availability of Naloxone (or Narcan) throughout Sheriff's Department's custodial facilities.

As previously reported, Sheriff's Department policy authorizes trained staff to administer Narcan when an overdose is suspected[101] or a person in custody is unresponsive.[102] During this reporting period, the Office of Inspector General received notifications for approximately 53 Narcan deployments. Office of Inspector General staff monitored the availability and accessibility of Narcan across different housing areas at CRDF and MCJ. This monitoring included site visits with the SBC chair and interviews with people in custody and custody staff.

Men's Central Jail

At MCJ, Office of Inspector General staff visited moderate observation housing (MOH), restrictive, protective custody, and general population housing areas, as well as the chapel. In units without open program space[103] such as general population, restrictive and protective custody, Narcan was generally available. Most housing rows had one or two devices affixed to laminated posters at the start of each row, however, as previously reported, the devices are inaccessible to people in custody. In MOH dorms, two Narcan devices were available and accessible to people in custody. A facility unit order requires "[a]ll MCJ dorms [be] supplied with four (4) doses of Narcan nasal spray."[104] Additionally, Narcan was not available in the chapel.

Incarcerated people housed in dorms reported needing additional Narcan to accommodate an average of 85 individuals in the event of a mass or multi-person emergency. Those in housing rows indicated they do not have access to Narcan from their cells or to grievance forms to report the inaccessibility. All people in custody who spoke with Office of Inspector General staff reported not receiving any training on Narcan administration and being unfamiliar with how to use it.

Deputies and CAs across housing locations at MCJ consistently reported carrying one or two Narcan devices on their person, confirmed that the Emergency Response Kits in their assigned area contained the required two Narcan devices, and confirmed that they had received training. Deputies and CAs who spoke with Office of Inspector General staff demonstrated varying levels of understanding of the department's policy on Narcan

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[101] See Los Angeles County Sheriff's Department, Custody Division Manual, § 5-03/060.15 Nasal Spray Administration for Suspected Overdoses.

[102] See Los Angeles County Sheriff's Department, Custody Division Manual, § 5-03/060.00 Response to Inmate Medical Emergencies.

[103] These units have linear configurations featuring cell rows.

[104] See Los Angeles County Sheriff's Department, MCJ Unit Order, §3-09-032 *Inmate NARCAN Program*.

maintenance, inventory replenishment, and post-incident reporting. Differences between the department's policy and a facility unit order may contribute to this variation, particularly regarding responsibility for inspecting devices and obtaining replacements.

Department policy, which governs Narcan administration by custody staff, assigns the facility training unit replacement requests, and tracking and inspecting Emergency Response Kits to ensure that devices are available and have not expired. In contrast, MCJ's unit order,[105] which governs the Narcan program for people in custody, directs staff to order Narcan through Access to Care Bureau (ACB) and track in the Custody Division Narcan Tracking System (CDNATS).[106] It also assigns specific inspection, reporting, and replacement duties to deputies, sergeants, and watch commanders.[107]

Court Line

In court line, Narcan remained broadly available in the Naloxone boxes, affixed to laminated posters throughout the area, and at the officer booth. As previously reported, people in custody cannot access the devices once they are placed in holding cells before being transported off-site or rehoused.

On September 13, 2023, a person in custody died from an accidental overdose after experiencing a medical emergency on a Court Services Transportation (CST) bus five days prior. In the administrative death review, the Department opened a corrective action plan (CAP) deploying Narcan on CST buses so that, in the event of another medical emergency on a CST bus, other people in custody could administer Narcan while Department staff transport the bus to a secure location to render emergency aid.

As reported in the above in-custody death section, on July 28, 2026, a person in custody died after experiencing a medical emergency while being transported to court on a CST bus. While the death was not caused by an accidental overdose, it raised the concern that Narcan was not available for people in custody to administer to the decedent while on the bus. Although custody staff, CHS staff, and paramedics rendered

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[105] See Los Angeles County Sheriff's Department, MCJ Unit Order, §3-09-032 *Inmate NARCAN Program*.

[106] Custody Operations Informational Bulletins, 2022 Informational Bulletins, Bulletin #2022-01, Custody Division Narcan Tracking System.

[107] The order requires four Narcan devices in each dorm and directs custody staff conducting Title 15 safety checks in dorms to report missing or altered Narcan devices to booth staff. Staff must also attempt to determine whether Narcan was administered to a person in custody and document their findings in the electronic Uniform Daily Activity Log (e-UDAL) and CDNATS. Narcan replacements must be stored in the watch commander's office and distributed only by the watch sergeant or watch commander.

emergency aid and administered Narcan to the incarcerated person once CST staff arrived at a secure location.

At the administrative death review, the Department acknowledged that, following the September 13, 2023, death, Narcan cartridges were placed on CST buses so that incarcerated persons on the bus had access. However, the Department reported that it stopped stocking the CST buses with Narcan after several Narcan cartridges went missing. Thus, while the CAP explored the feasibility of making Narcan available on buses for administration by inmates, the Department instead recommended that CST staff pass Narcan to the inmates to administer.

Century Regional Detention Facility

At CRDF, Office of Inspector General staff visited general population, Forensic In-Patient (FIP) Stepdown, high observation housing (HOH), moderate observation housing (MOH), restrictive housing, the inmate worker dorm,[108] medical intake, and reception center. Office of Inspector General staff observed Narcan devices generally available and accessible in housing units with open program space such as general population and MOH dorms. In these units, two Narcan devices are commonly attached to laminated posters displaying information about the medication. People in custody reported that the devices are not always within reach. For example, although most posters on the wall behind deputy stations had two devices, their placement in areas that prohibit access to people in custody make the devices inaccessible. As with MCJ, incarcerated people at CRDF also reported a lack of training on Narcan administration and unfamiliarity with how to use it.

In units without open program space, Narcan availability and accessibility varied. In HOH, FIP Stepdown, and restrictive housing, Narcan was generally available but not readily accessible to people in custody due to their classification status. Mental Health Assistants also do not have access to Narcan within the FIP Stepdown units and indicated they have not received training. In the reception center, Narcan was available in open areas but not accessible to incarcerated people once they are placed in holding cells. Narcan remains available and accessible in the medical/detox module where incarcerated individuals identified at intake as being at risk for withdrawal or requiring medical observation are temporarily housed and monitored.[109]

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[108] The inmate worker dorm is a housing unit for incarcerated workers who perform facility maintenance, kitchen, and operational duties.

[109] The module consists of three pods. each medical/detox pod was equipped with Narcan devices.

Deputies and CAs across housing locations at CRDF consistently reported carrying one or two Narcan devices on their person.[110] Custody staff also confirmed that the Emergency Response Kits in their assigned area contained the required two Narcan devices and displayed the kits upon request.[111] All deputies and CAs who spoke with Office of Inspector General staff demonstrated understanding of the department's policy on Narcan maintenance, inventory replenishment, administration, and post-incident reporting, and confirmed that they had received training and participated in scenario-based drills.

Recommendations for Improved Narcan Access

While the Office of Inspector General acknowledges the Sheriff's Department efforts, the continued lack of Narcan accessibility for people housed in units without program space is noncompliant with the Board's motion. Building on recommendations in our previous quarterly report, the Office of Inspector General also recommends the Department:

1. Require that each custody facility adopt a unit order that aligns with department policy and clearly defines staff responsibilities for maintaining and restocking Narcan for people in custody.

2. Explore hosting town hall meetings, periodically show a Narcan instructional video for people in custody in common areas such as in reception and the clinics, and include Narcan use information in the orientation guide.[112]

3. Make Narcan available in all areas where people in custody are located, including on CST buses.

4. Explore offering Narcan to people during health screenings at intake.

5. Provide Narcan training and devices to MHAs.

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[110] See Los Angeles County Sheriff's Department, Custody Division Manual, § 3-06/055.00 *Mandated Equipment* recommends that personnel wear or carry "two (2) doses of Naloxone Nasal Spray (Narcan)."

[111] See Los Angeles County Sheriff's Department, Custody Division Manual, *§ 3-14/090.00 First Aid and Emergency Response Kits*; § 5-03/060.15 *Nasal Spray Administration for Suspected Overdoses*.

[112] See Los Angeles County Sheriff's Department, Custody Division Manual, § 5-01/010.05 A Guide Through Custody - Los Angeles County Jail.

Protection Against Sexual Assault in Jails – PREA Compliance

The Prison Rape Elimination Act (PREA) establishes national standards to prevent, detect, and respond to sexual abuse and sexual harassment in correctional environments.

On June 30, 2026, the Los Angeles County Board of Supervisors passed a motion titled *Survivors First: Protection Against Sexual Assault in the Los Angeles County Jails*. The motion directs the Office of Inspector General to continue to monitor and engage people in custody on PREA compliance and the Department's response to complaints and allegations involving sexual abuse and sexual harassment.

PREA Investigations and Staffing

PREA Standard § 115.71(a) requires that, when an agency conducts its own investigations into allegations of sexual abuse and/or sexual harassment, it does so "promptly, thoroughly, and objectively for all allegations." PREA Standard § 115.11(c) requires each jail facility to designate a PREA Compliance Manager (PCM) who has "sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards."

The Department's Office of PREA Compliance (OPC) budget includes seven sergeant positions, of which six are serving as PCMs. PCMs oversee all aspects of PREA compliance at custody facilities, including conducting investigations of all allegations of sexual abuse and/or sexual harassment involving staff. As of this report, two OPC sergeant positions remain vacant. PREA-related allegations against people in custody are investigated by two investigators assigned to the Jail Investigations Unit (JIU).

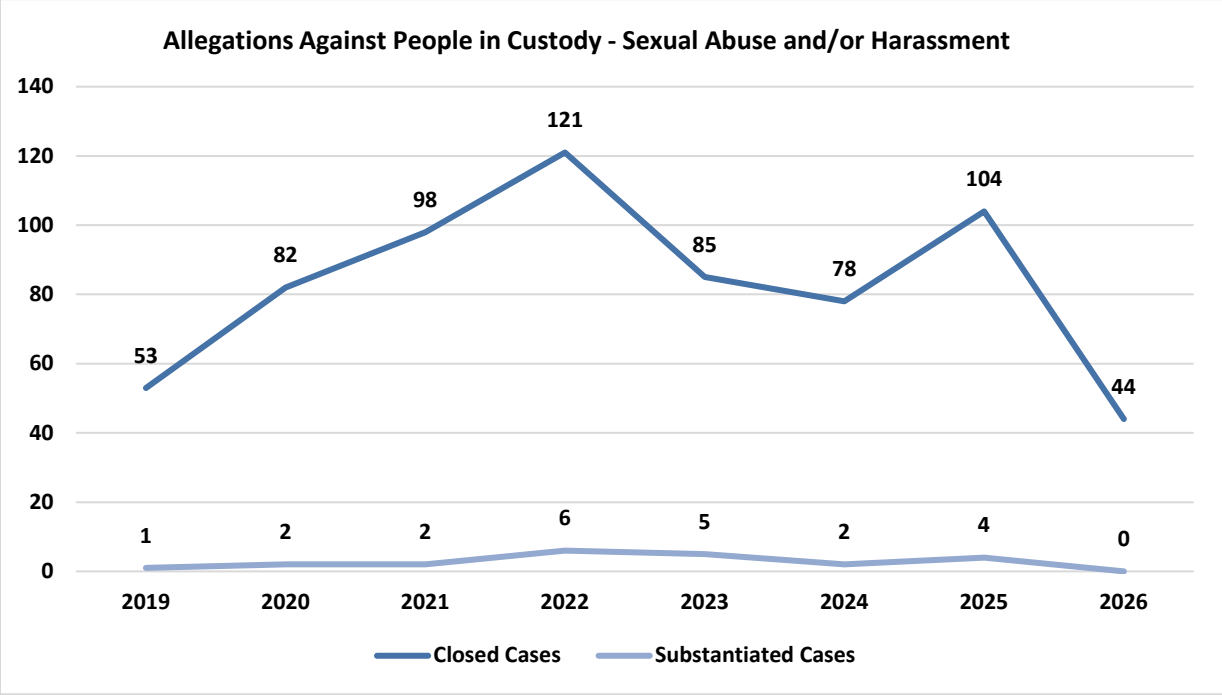
Between January 1, 2022, and October 8, 2026, the Department reports receiving a total of 1,699 PREA-related complaints, of which 1,404 met the definition of a PREA-related allegation of sexual abuse and/or sexual harassment.

The Department provided data showing that the OPC has had a backlog of pending PREA-related allegations since 2022. As of October 8, 2026, there are 280 PREA-related allegations pending.

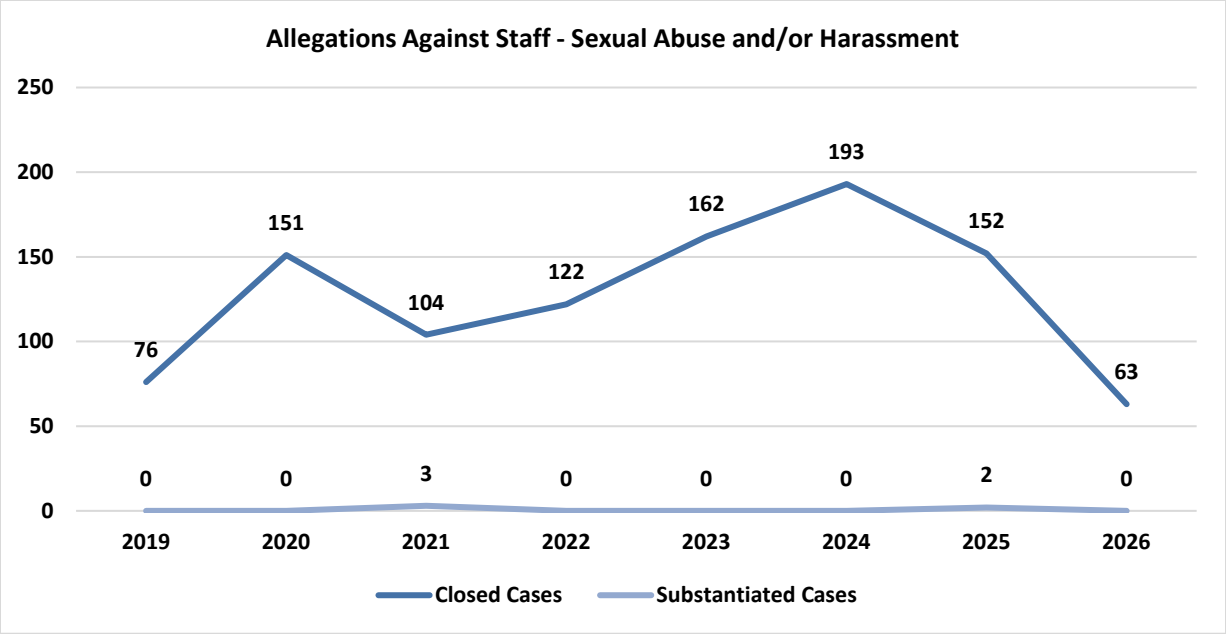
Pending PREA-related Allegations by Year					
Allegation Type	**2022**	**2023**	**2024**	**2025**	**2026**
Allegations Against Staff - Sexual Abuse	1	2	7	17	45
Allegations Against Staff - Sexual Harassment	1	3	1	60	54
Allegations Against People in Custody - Sexual Abuse	0	2	2	8	38
Allegations People in Custody - Sexual Harassment	3	4	12	7	13
Total	**5**	**11**	**22**	**92**	**150**

The Department's failure to fully staff the OPC sergeant positions and assigning only two PREA investigators to JIU limits the Department's ability to conduct prompt and thorough investigations into PREA-related allegations and directly contributes to the growing backlog.

The Department provided data showing the dispositions of closed investigations into PREA-related allegations from 2019 through 2026. The charts below display the total number of closed investigations compared to the number of those which the Department determined to be substantiated.[113]



[113] Substantiated investigations into PREA-related allegations mean that the allegation was investigated and determined to have occurred.



The number of substantiated cases relative to the number of allegations raises concerns regarding the thoroughness and objectivity of the Department's investigations into PREA-related allegations due to the low number of substantiated cases.[114]

Data Analysis and Transparency

PREA Standard § 115.87 requires agencies to "collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control." PREA Standard § 115.88 requires agencies to prepare an annual report of its "findings and corrective actions for each facility, as well as the agency as a whole," and make the report "readily available to the public through its Web site."

The Office of Inspector General previously reported on the Department's failure to timely publish PREA-related data.[115] The *PREA Reports* section of the Department's website Transparency page for Custody Division Reports was last updated in the third quarter of 2025, and the most recent published PREA annual report dates back to 2022.

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[114] The Office of Inspector General raised these concerns previously in its *Report Back on the Sheriff's Department's Compliance with the Prison Rape Elimination Act (PREA)* (August 12, 2024), at page 9.

[115] *See* Report Back on the Sheriff's Department's Compliance with the Prison Rape Elimination Act (PREA) (Item NO. 10, Agenda of March 19, 2024), at 10.

Recommendations to Improve Protections Against Sexual Assault in Jails

1. The Department should comply with PREA standard § 115.71 by ensuring all investigations into allegations of sexual abuse and/or sexual harassment are conducted promptly, thoroughly, and objectively.
2. The Department should prioritize staffing the two vacant OPC sergeant positions.
3. The Department should assign more investigators to JIU to conduct investigations into PREA-related allegations against people in custody.
4. The Department should comply with PREA standard § 115.87 and § 115.88 by collecting accurate, uniform PREA-related data and publishing and posting an annual report on the Department's website.

Reducing Harms for Incarcerated Transgender, Gender-Diverse and Intersex People

On April 7, 2026, the Los Angeles County Board of Supervisors passed a motion titled *Reducing Harm for Transgender, Gender-Diverse, and Intersex (TGI) People Who Are Incarcerated in the Los Angeles County Jails*. The motion directs the Office of Inspector General to engage with TGI people in custody and evaluate conditions related to gender-affirming care, safety, and overall wellbeing and to report quarterly based on these assessments. This update evaluates screening and intake procedures, housing considerations, safety concerns within K6G housing, shower privacy, recent updates to the Gender Identity Review Board (GIRB)[116] process, and training provided to custody staff who interact with TGI individuals.

Throughout this reporting period, Office of Inspector General staff engaged with TGI people housed at MCJ, Century Regional Detention Facility (CRDF), TTCF and collaborated with Department's Office of PREA Compliance (OPC), Los Angeles Sheriff's Department leadership, and the American Civil Liberties Union (ACLU). This collaboration evaluated implementation of the Board's directives, identified areas of progress and concern, and gathered information concerning TGI people's experience in jails.

Classification

The Department's Custody Division Manual (CDM) *Section 5-02/050.00 Classification, and Housing of Gay, Gender Non-Conforming and Transgender Inmates* requires

[116] The Gender Identity Review Board is a meeting to establish guidance concerning safety, medical needs, and housing of TGI people in custody.

individualized classification, screening, and housing of LGBTQ+ (lesbian, gay, bisexual, transgender, queer) people in custody, consistent with PREA Standard § 115.42 and the *Robertson v. Block* Settlement Agreement.[117] The Department's Population Management Bureau (PMB) conducts initial custody classifications for people who arrive in custody at IRC. The classification process includes a series of questions designed to determine the appropriate security level and housing determinations.[118]

If a person identifies as LGBTQ+ during their initial custody classification screening, OPC staff conduct a secondary K6G interview to determine whether the person would be appropriately housed in the K6G dorm, in administrative segregation, or in general population.[119] If a person entering IRC identifies as TGI, OPC staff conduct a Gender Identity Interview (GII) to determine whether the person would be appropriately housed at CRDF, in the K6G dorm, in administrative segregation, or in general population.

Office of Inspector General shadowed OPC staff who were conducting K6G and GII interviews. OIG staff observed that these interviews are often conducted in or near housing units lacking adequate privacy, allowing sensitive information to be overheard by other people in custody. Moreover, because OPC staff is tasked with administering both interview forms, LGBTQ+ people in custody are often located throughout IRC, TTCF Module 231, and in permanent housing by the time the OPC staff can administer the interviews and finalize the person's classification.

To ameliorate privacy concerns and ensure that people in custody are classified prior to being placed in a permanent housing location, the Office of Inspector General recommends that PMB complete K6G and GII interview screenings during initial classification at intake. This allows staff to obtain sensitive information in a private setting that supports candid communication and reduces the risk of personal details being overheard, which aligns with the confidentiality and trauma-informed practices required by PREA Standard § 115.41. Consolidation also eliminates the need for LGBTQ+ and TGI people in custody to repeat information across multiple interviews, allowing PMB to apply screening results immediately, and make timely, individualized

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[117] *Robertson, Belisle, and Rumph v. Block et al.* was a class action challenging the conditions of confinement for male gay people in custody in the Los Angeles County Jail. The suit focused on housing, safety, and daily living conditions.

[118] See CDM section 5-10/030, Inmate Classification and Identification.

[119] K6G is a segregated housing unit for individuals who identify as LGBTQ+ and limits interaction with the general population. Placement in the K6G housing requires an interview to determine suitability.

housing assignments. The Office of Inspector General has presented recommendations to PMB leadership, who are currently evaluating options to streamline the classification process.

Safety in K6G Dorms

Between January 1 and September 30, 2026, the Department received 18 PREA allegations of inmate-on-inmate sexual abuse and sexual harassment in the K6G dorms. Nine cases resulted in investigative conclusions, eight unsubstantiated and one unfounded, while nine are pending. Interviews in the K6G dorms at MCJ indicate a persistent, high incidence of sexual abuse in these dorms, with many incidents going unreported due to fear and low confidence in reporting and investigative processes.

Investigative review was hindered by an outdated computer system that does not allow location-specific filtering of crime reports, requiring staff to manually search each report individually.[120]

Office of Inspector General staff conducted interviews with TGI people housed in two MCJ K6G dorms in which several people raised concerns about safety. Office of Inspector General staff routinely monitor K6G dorms, and people in custody have reported increased concerns about violence and gang influence. Several people housed within the K6G dorms stated that the dorms felt safer when deputies entered regularly and maintained an active presence, suggesting that direct supervision may reduce sexual assaults and harassment and deter violent behavior.

The Office of Inspector General discussed concerns about K6G dorm safety with MCJ facility leadership. MCJ leadership stated that, due to staffing shortages, they would be unable to assign deputies to be positioned inside K6G dorms.[121]

Further, MCJ leadership articulated that positioning staff members inside the dorms presented concerns regarding officer safety, despite housing more than one hundred people inside the dorms.

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[120] SECDA stands for the Sheriff's Electronic Criminal Documents Archive, which is the digital record management and archival system used by LASD. Department personnel retrieve stored records and documents through the Los Angeles Regional Crime Information System (LARCIS).

[121] The Department employs staff who are positioned in an officer booth and are tasked with providing direct supervision and monitoring CCTV of K6G housing spaces. However, each dorm houses over one hundred people in custody, and staff positioned in the K6G officer booths have reported it is difficult to visually monitor all activity.

MCJ leadership indicated that they would explore alternatives to reducing violence in the K6G dorms. In its continuing monitoring of conditions in the K6G dorms, OIG will assess whether additional supervision or alternative monitoring strategies may help reduce assaults and harassment.

Showers

The Office of Inspector General previously reported on the Department's compliance with the PREA standards aimed at protecting TGI people in custody, based on the unique risks these populations face while incarcerated.[122]

PREA Standard § 115.42 (f), requires that transgender and intersex people in custody be given an opportunity to shower separately from other people in custody. The National PREA Resource Center states that facility layout will inform the best practices in implementing this standard, and that this standard "may be accomplished either through physical separation (e.g., separate shower stalls) or by time-phasing or scheduling (e.g., allowing an inmate to shower before or after others)."
TGI people in custody housed in K6G dorms at MCJ have access to a dormitory shower, that does not afford TGI people the opportunity to shower alone as required by PREA Standard § 115.42. During the second quarter of 2025, the Department's Custody LGBTQ+ Committee recommended that the Department implement a specified shower time for TGI people housed in K6G dorms to individually utilize dorm showers. The Department's unit order outlined expectations for TGI shower times at MCJ, specifically requiring that staff assigned to K6G dorm officer booths announce the shower time to the dorm, ensure that the shower is only occupied by a single occupant and clear of onlookers, and log that the shower time allotment was completed in the electronic Uniform Daily Activity Log (e-UDAL).

The Office of Inspector General has routinely monitored the implementation of TGI shower time for the past four quarters. People in custody housed in K6G dorms have reported that, despite the Department installing signs in the dorms informing people in custody of TGI shower times, Department staff positioned in the officer booth do not monitor TGI shower time to ensure that TGI people in custody have the opportunity to shower alone. These reports were confirmed by Department staff positioned in K6G officer booths, who reported that they are not provided with adequate resources to monitor and enforce that the shower is only occupied by a single occupant and clear of onlookers during TGI shower time.

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[122] 28 CFR 115.42.

The Department has reported that it has made progress with installing partitions in one of the two K6G dorms at MCJ, in an effort to comply with PREA Standard § 115.15 (d), which requires that people in custody are enabled to "shower . . . without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia." PREA Standard § 115.18 further provides that, when designing or modifying facilities, "the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect inmates from sexual abuse."

MCJ facility leadership did not consult with the Department's PREA Coordinator prior to installing the shower partition in the K6G dorm. The partition, depicted in the photograph below along with a makeshift shower curtain, does not provide sufficient privacy. The makeshift shower curtain was rigged by people in custody to provide a higher level of privacy. However, these makeshift shower curtains present risks to both people in custody and staff. The shower curtains obstruct a large area of the dorm showers, where people housed in the dorm and staff conducting safety checks could be assaulted.



Gender Identity Review Board

As the Department continues to incrementally improve access to gender-affirming resources, developments in classification and housing assignments have become increasingly important for ensuring safety and stability of TGI people in custody. Recent updates to the GIRB process reflect ongoing efforts to strengthen the process. The

OPC is refining the process by attempting to increase the frequency of GIRB meetings, agreeing to provide a written summary to meeting participants, and ensuring that individuals who request a GIRB receive timely communication about the outcome. The Office of Inspector General acknowledges the Department's prompt housing reassignment when a request for gender affirming housing is approved, which helps reduce the amount of time people in custody spend in non-affirming or potentially unsafe housing.

Staff Training

The Office of Inspector General attended the Deputy Empathy Awareness Training developed by the Center of Health Justice, which provides programming and services to LGBTQ+ people in custody and is specifically designed for custody staff. The training covers respectful terminology, risks and concerns specific to LGBTQ+ people in custody, and strategies for establishing rapport and trust. The OPC is collaborating with MCJ training staff to integrate this instruction into ongoing staff development. The Office of Inspector General will continue to monitor the department's efforts to provide training on an ongoing basis and assess its implementation as part of its broader PREA and TGI oversight activities.

Conclusion

The Department has taken meaningful steps to improve conditions for TGI people in custody, and these efforts reflect a growing commitment to meeting the Boards directives. Despite improvements, issues including K6G screening at intake and dorm safety, would benefit from continued focus. Adjusting existing practices and maintaining constant oversight will help foster a safer and supportive environment for TGI people in Department.

Recommendations for Reducing Harms to TGI People in Custody

1. PMB should complete K6G and GII interview screenings during initial classification at intake to allow staff to obtain sensitive information in a private setting that supports candid communication and reduces the risk of personal details being overheard, which aligns with the confidentiality and trauma-informed practices required by PREA Standard § 115.41.

2. The Department should explore alternatives to reducing violence in the K6G dorms, including by having deputies enter regularly and maintain an active presence to reduce sexual assaults and harassment and deter violent behavior.

3. The Department should require that staff comply with PREA Standard § 115.15 (f) by ensuring that TGI people in custody have the opportunity to shower alone.

4. The Department should ensure that custody facilities comply with the requirements of PREA Standard § 115.18 by consulting with the Department's PREA Coordinator prior to modifying any custody facility.

5. The Department should ensure MCJ staff remove makeshift shower curtains in MCJ dorm showers which present risks to both people in custody and staff.

Meal Preparation and Distribution at Men's Central Jail

The Office of Inspector General frequently receives complaints from people in custody about meal preparation and distribution for both regular and special diets, as well as concerns about meal quality and missing or damaged food items. Title 15 of the California Code of Regulations (Title 15) requires that food be prepared and served "only under the immediate supervision of a staff member" and that people in custody receive three meals within each 24-hour period, with at least one meal including hot food.[123] When the interval between the evening and morning meals exceeds 14 hours, incarcerated people must be provided with supplemental food.[124]

The Sheriff's Department policy reinforces Title 15 requirements for frequency of serving, the inclusion of hot food, and supervision of meal distribution.[125] A MCJ unit order uses broader language for meal preparation, requiring that, "[a]ll meals . . . be planned and prepared under the supervision and/or direction of the food manager."[126] By including "and/or direction" as an alternative to "supervision," the unit order creates ambiguity about whether immediate staff supervision is required during meal preparation. Unlike its broader language on meal preparation, the unit order reaffirms that custody staff must supervise the distribution of meals.[127]

It also requires that all special diets be "placed directly in front of the floor's main control module to be supervised at all times by custody staff."[128] Additionally, custody staff must

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[123] Cal. Code Regs., tit 15, § 1240.

[124] Cal. Code Regs., tit 15, § 1240.

[125] See Los Angeles County Sheriff's Department, Custody Division Manual, § 5-13/010.00 *Inmate Meals*.

[126] See Los Angeles County Sheriff's Department, Men's Central Jail Unit Orders, § 5-06-000 Inmate Meals.

[127] The order requires custody staff to walk the housing rows with incarcerated workers as all meals are distributed to ensure that each person receives the correct meal.

[128] MCJ Unit Order § 5-06-000 Inmate Meals.

be “immediately present” during distribution to verify that each special diet contains all items listed on the special diet menu spreadsheet.[129]

During this reporting period, Office of Inspector General staff monitored meal preparation and distribution across five housing locations at MCJ: one general population housing row, one moderate observation housing (MOH) dorm, one restrictive housing row, one protective custody housing dorm, and one protective custody housing row. Monitoring included a review of MCJ’s CCTV video of breakfast, lunch, and dinner services from July and September 2026, multiple site visits, and interviews with people in custody, food services staff, and custody staff. Office of Inspector General staff reviewed CCTV video of a total of 63 meal services across the aforementioned housing areas. For three locations (general population, protective custody row and restrictive housing), video from one date per month was reviewed, and for the remaining two locations (MOH dorm and protective custody dorm), video from two dates per month were reviewed.

First, the Office of Inspector General’s review of CCTV found 16 occasions when the interval between the evening meal and the following morning’s meal exceeded 14 hours. The problem occurred across all housing areas reviewed. The time exceeding 14 hours ranged from a few minutes to more than six hours. Although Office of Inspector General staff could not verify whether supplemental food was provided in these instances, people in custody often report that they receive no additional food during extended gaps between meals. Additionally, breakfast and lunch were served together on at least two occasions – another issue people in custody frequently report.

Second, the Office of Inspector General noted issues with the Department’s practices during meal preparation and distribution. Custody staff at MCJ delegated meal preparation and distribution to incarcerated workers in all five housing areas with minimal or no supervision. Custody staff picked up special diets and bulk food items from the kitchen and transported them to housing floors via freight elevators. Once the food arrived on the floor, incarcerated workers prepared regular diet meals and stored special diets in either a mess hall, a dayroom or the hall. The meals were then transported to housing areas. In dorm housing, incarcerated people housed in the unit handled distribution, while in linear modules, the incarcerated workers distributed the

[129] MCJ Unit Order § 5-06-000 Inmate Meals.

meals.[130] Custody staff directly supervised distribution in only one of the five housing areas on all dates reviewed. Custody staff's failure to supervise meal preparation and distribution is non-compliant with both Title 15 and Department policy and creates the opportunity for meal tampering and contraband movement throughout the jail.

Recommendations for Meal Preparation and Distribution

The Office of Inspector General recommends that the Department align its practices with both law and policy by revising its MCJ unit order to be consistent with Title 15, ensuring that meals are served within the required time limits, and requiring immediate staff supervision of meal preparation and distribution.

Use-of-Force Incidents in Custody

The Office of Inspector General monitors the Sheriff's Department's use-of-force incidents, institutional violence, and assaults on Department or CHS personnel by people in custody.[131] The Department's most recent force report is for use-of force-incidents in custody through the fourth quarter of 2025. This report and reports for prior quarters may be found on the Department website's transparency section under the page for use of force.

Update on Rosas Monitoring

The Assistant Sheriff of Custody Operations presented an update on the Department's compliance with the *Rosas v. Baca* Settlement Agreement and Release[132] and Rosas Implementation Plan at the Los Angeles County Board of Supervisors meeting on October 6, 2026. The Assistant Sheriff reported that uses of force in the jails have substantially decreased over the past ten years and that the Department has improved its compliance with the Rosas Settlement Agreement. The Assistant Sheriff also

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[130] For breakfast and lunch, incarcerated workers assembled cold bag meals by filling clear bags with food items and loading the completed bags onto crates for later distribution. In certain housing areas, they stocked crates with bulk food items, sometimes without counting the items. Bulk packing and storage occurred in mess halls, supply rooms, dayrooms and hallways. For dinner service, incarcerated workers staged insulated transport carts carrying prepackaged meals in mess halls, supply rooms, and hallways. The carts are designed to maintain required food holding temperatures for up to four hours, however, incarcerated workers sometimes removed the prepackaged meals and loaded them onto crates before distribution.

[131] Institutional violence is defined as assaultive conduct by a person in custody against another person in custody.

[132] The Rosas Settlement Agreement resolved a federal class action lawsuit alleging a pattern of excessive uses of force in the Los Angeles County jails' downtown facilities. (*Rosas v. Luna* (C.D.Cal., No. CV 12-00428 DDP), formerly *Rosas v. Baca.)*

reported fewer use-of-force cases in which the Department and the panel of monitors appointed under the agreement (Panel) disagree about whether the force was objectively reasonable and consistent with Department policy.

The Panel filed its Seventeenth Report to the United States District Court on September 8, 2026. Of the 50 use-of-force cases the Panel reviewed for the seventeenth reporting period, there were three cases in which the Department determined the force was objectively reasonable, but for which the Panel found the force violated Departmental policy. One of these cases, which the Panel discussed in its report, was described as "horrific" by plaintiff's counsel in a letter to the Board.[133] The following is a summary of the use of force, the Department's disciplinary findings, and the Office of Inspector General's analysis of the investigative findings and discipline.

Factual Summary

On September 30, 2024, a person in custody at TTCF was seated at a dayroom table, handcuffed behind his back, and receiving medical care from CHS staff. After an alleged disagreement with the nurse providing care, the person stood up. A deputy immediately performed a takedown, swinging the person into the metal frame of a cell window before taking him to the ground. Additional Department personnel responded, applied control holds, restrained the person in a RIPP Hobble,[134] and transported him in a safety chair[135] to the jail clinic. He was then transported to Los Angeles General Medical Center, where he was diagnosed with a broken neck resulting in paralysis.[136] He died in a rehabilitation facility approximately nine months after the use of force.

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[133] Letter from Peter Eliasberg, Chief Counsel, and Melissa Camacho, Senior Staff Attorney, ACLU Foundation of Southern California, to L.A. County Bd. of Supervisors. (Sept. 25, 2026) p. 2.).

[134] A RIPP Hobble is a polypropylene webbing restraint that law enforcement officers use to secure a person's legs and restrict movement during transport.

[135] A safety chair is used for the short-term, secure transport of a person the Department has identified as violent or a high security management risk.

[136] The person's diagnosis was a facet fracture of the C3 and C4 vertebrae, C3 anterior subluxation, and a C2-T1 decompression injury.

Department Disciplinary Determinations

The Department's Executive Force Review Committee (EFRC), a panel of commanders, determined that the force and tactics were within Department policy.[137] As a result, the deputy was not charged with using excessive force.

The EFRC Panel sustained findings that the deputy violated the Department's Manual of Policy and Procedures (MPP) *Sections 3-01/030.10, Obedience to Laws, Regulations, and Order* (as it pertains to Custody Division Manual (CDM) *Section 7-01/010.00, Force Prevention Principles*, and/or MPP *Section 3-01/050.10, Performance to Standards*) for failing to use de-escalation tactics prior to the takedown. The deputy received a two-day suspension without pay.

The EFRC Panel also sustained findings that the responding sergeant violated MPP section 3-01/050.10, Performance to Standards, for failing to:

- properly assess the person for injuries resulting from the takedown;
- assess the person for any head or neck injuries after observing blood on his head;
- request a medical response after observing blood on the person's head
- gather details of the takedown from the involved deputy;

The sergeant received a two-day suspension without pay.

Analysis

The Office of Inspector General's review of the investigation found ample evidence in the use-of-force package suggesting that the deputy and the sergeant made false statements in violation of MPP section 3-01/040.70, Dishonesty/False Statements.

Provision 13.1 of the Rosas Implementation Plan requires the Department have a "firm policy of zero tolerance for acts of dishonesty." It further provides "[i]f the Department does not terminate a member who is found to have been dishonest . . . the Department should document the reasons why the member was not terminated."[138]

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[137] The Department's force policy provides: "Department members shall use only that force which is objectively reasonable. Unreasonable force is that force that is unnecessary or excessive given the totality of the circumstances presented to Department members involved in using force." MPP section 3-10/030.00 - *Unreasonable Force and Duty to Report and Intercede*.

[138] Additionally, Rosas Implementation Plan, provision 13.2 provides that all findings of dishonesty or excessive force by the Department should be reported to the Office of Inspector General each quarter.

In this case, neither the subject deputy nor the responding sergeant was charged or investigated with potential violations of section 3-01/040.70, even though both made several material statements that were directly contradicted by the CCTV video of the incident.

Subject Deputy

In his post use-of-force report, the deputy stated that: (1) before the use of force, the person in custody "charged" him; (2) he was "unable to retreat away from the [person's] advance" and thus did not have time to de-escalate, (3) he "applied downward pressure to [the person] to safely guide him to the floor"; (4) he placed his knee on the person's back to maintain control; and, (5) he placed the person in custody in the recovery position after the use of force.[139]

First, the deputy reported that the "[person] who was seated at the table, stood up from the seated position, turned to his right side and charged towards [the Deputy]." The deputy repeated this statement in his Internal Affairs Bureau interview, at one point clarifying that by "charged" he meant the person "[ran] towards. . . or in [the deputy's] direction in an aggressive manner."[140] The deputy could not recall how many steps the person took when he allegedly charged. The deputy also wrote an incident report alleging that the person committed battery on a peace officer, stating that the person could have "potentially" ran into, kicked, punched, head-butted, or kneed him.[141]

However, after reviewing the CCTV video during the Internal Affairs interview, the deputy retracted his statement that the person had charged him. He stated instead that the person stood up from a seated position and "leaned in [the Deputy's] direction," which the Deputy interpreted as the person "coming towards [him]."[142]

Second, the Deputy stated that he did "not have enough time to use any de-escalation technique" because the person "ran towards [the deputy] in an aggressive manner" and

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[139] This analysis is based on the OIG's review of the Department's use-of-force investigation file, including the involved deputies' reports, Internal Affairs Bureau interviews, and CCTV video.

[140] The TTCF watch lieutenant who was on scene at the time of the incident stated that she ordered a supervisor to escort the person to Los Angeles General Medical Center because she had been told that the person had "assaulted staff."

[141] The deputy's report alleged a violation of Penal Code § 243(c)(1).

[142] A second Deputy involved in the use of force incident never alleged that the person charged the subject deputy. He stated only that the person "stood up on his own without any warning" and "faced [the subject deputy]," at which point the subject deputy "went hands on."

that he could not retreat before the takedown because his back was against a wall. During the Internal Affairs interview, the interviewer asked whether there were any indicators that the person was assaultive apart from the person "standing up, turning towards [the deputy] and charging towards [the deputy]." The deputy said there were none.

After reviewing CCTV video, however, the deputy acknowledged that he had approached the person, or "closed the distance," before the person stood up. The deputy also retracted his claim that his back was against a wall. He maintained that there was "not much room" for him to safely reposition, even though he admitted he could have retreated to either side of the person.

These statements contradict one another and undercut the deputy's original claim that he did not have time to de-escalate before using force. The deputy admitted that the only behavior he perceived as assaultive was the person "standing up and turning towards [the deputy]." After reviewing the video, however, the deputy acknowledged that he approached the person before the person stood up, meaning there was no perceivable threat at the time the deputy chose to approach the person rather than using de-escalation tactics. Choosing to "close the distance," therefore created the exigency that the deputy claimed necessitated the force. The deputy's revised claim that he had neither the time nor the space to de-escalate is directly contradicted by his decision to approach the person.

The EFRC Panel disagreed with the deputy's assertion that he had no opportunity to use de-escalation tactics before using force, and it sustained the de-escalation findings described above. Although the deputy received a two-day suspension for these violations, the Department did not identify his conflicting statements about his alleged inability to de-escalate as potentially false or dishonest statements, in violation of MPP Section 3-01/040.70, Dishonesty/False Statements.

Third, the deputy denied that he "slammed [the person] to the ground insisting instead that he "guided [the person] to the ground . . . as safely as possible." Although the extent of the person's injuries contradicts this account, the deputy refused to acknowledge the forceful nature of the takedown throughout the investigation.

During the investigation, the deputy acknowledged seeing the person bleeding from his head. When Internal Affairs asked whether the bleeding concerned him, he stated, "not really," explaining that the blood could have come from a "chipped tooth," the person

"hit[ting] his nose on the floor," or the person "bust[ing] his lip." [143] When Internal Affairs asked how "safely guiding" the person to the floor could have caused a chipped tooth or a busted lip, the deputy replied that he did not "hear a thump . . . see [the person's] head bounce off the floor . . . or connect with the floor in a violent manner."

The deputy's own explanations for the blood are inconsistent with his claim that he safely guided the person to the ground. His account is also contradicted by other witnesses. The second deputy at the scene described the takedown as the subject deputy "thr[owing the person] down on the floor." Several people in custody housed in the module heard the deputy "slam [the person] to the door," heard a "thud," and observed the deputy "tackle" the person into the wall.

After the deputy viewed the CCTV video, the Internal Affairs interviewer asked whether he still believed he had safely guided the person to the ground. The deputy said he did.

Fourth, the deputy stated that after the takedown, he used control holds and placed his knee in the small of the person's back to "maintain control" of the person who "resisted by rocking his body back and forth." The second deputy who helped by applying control holds to the person's legs, stated that the person was not moving or resisting in any way after the takedown. The person himself stated that, immediately after the force, he was unable to move and knew that "something was f***** up." After reviewing CCTV video, the subject deputy acknowledged that he placed his knee on the person's upper torso, rather than the small his back. He did not, however, retract his statement that he used control holds to overcome the person's alleged resistance.

Fifth, the deputy stated that because he was concerned about the person's bleeding, he placed the person in the recovery position. However, deputies who arrived to relieve him stated that they moved the person into the recovery position about one to two minutes after the subject deputy left, because the person could not breathe. After watching CCTV video, the deputy retracted his statement and acknowledged that he did not place the person in the recovery position before he was relieved.

Responding Sergeant

The sergeant who responded to the scene approved the deputy's use-of-force report. She reviewed the CCTV video of the use of force before reading and approving the report. Even so, she stated the CCTV video showed the person "charging" the Deputy before the use of force and the deputy "safely guid[ing]" the person to the floor. The

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[143] One deputy who witnessed the force expressed concern, stating to the Internal Affairs investigators that he wanted to ensure that the person received immediate medical care. This deputy requested additional deputy personnel, a sergeant, and a nurse with a gurney following the use of force.

sergeant could not recall whether the person was handcuffed during the incident or how many steps he took toward the deputy when he allegedly charged.

The deputy, after reviewing the video during his Internal Affairs interview, acknowledged that portions of his report were inaccurate. The sergeant, by contrast, reviewed the same video during her Internal Affairs interview and affirmed that the deputy's report was consistent with the video after confirming it was the same video she watched immediately following the incident and before approving the use-of-force report.

When Internal Affairs investigators asked whether video showed the person charging the deputy and the deputy safely guiding the person to the floor during the takedown, the sergeant said it did.

Conclusion

The CCTV video of the use of force directly contradicts the statements the subject deputy made in his use-of-force report. After reviewing the video during his Internal Affairs interview, the deputy admitted that portions of his report did not accurately reflect the incident but maintained portions of his report were accurate when they were not, specifically that he did not have the time or space to de-escalate, that he safely guided the person to the ground, and that the person resisted after the takedown.

The sergeant, despite being shown the same evidence, did not retract her statements that the deputy's report accurately described the incident. Although both the deputy and the sergeant made statements that the video clearly contradicts, and for at least some of the statements maintained their veracity, the Department did not charge either of them for potential violations of MPP Section 3-01/040.70, Dishonesty/False Statements.

The Department's failure to investigate, let alone discipline, the deputy or the sergeant for potential acts of dishonesty raises concerns regarding the Department's compliance with provision 13.1 of the Rosas Implementation Plan. The Department cannot maintain a "firm policy of zero tolerance for acts of dishonesty" if it does not even identity dishonesty. The Office of Inspector General recommends that Department follow its own policy and provision 13.1 of the Rosas Implementation Plan by appropriately charging, investigating, and holding accountable staff who make false statements.

Sheriff's Department's Service Comment Reports

Under its policies, the Sheriff's Department accepts and reviews comments from members of the public about departmental service or employee performance.[144] The Department categorizes these comments into three categories:

- External Commendation: an external communication of appreciation for and/or approval of service provided by the Sheriff's Department members;
- Service Complaint: an external communication of dissatisfaction with the Sheriff's Department service, procedure, or practice, not involving employee misconduct; and
- Personnel Complaint: an external allegation of misconduct, either a violation of law or Sheriff's Department policy, against any member of the Sheriff's Department.[145]

The Sheriff's Department has a complaints dashboard that can be sorted by date range, with options to narrow the results by practice area (such as Patrol or Custody), rank, or station or unit.

Auditor-Controller's Reviews of the Sheriff's Department's Incident Reporting Process

The Auditor-Controller (A-C) evaluated the design of the Sheriff's Department's public complaints and inmate grievance process report titled *Sheriff's Department – Incident Reporting Process*. Many of issues discussed in the A-C report reflect concerns noted by the Office of Inspector General in its reporting, including significant delays in investigating complaints and grievances, the lack of a process to ensure availability of inmate grievance forms in the custody facilities, and the necessity for training on complaint intake. The Office of Inspector General agrees with the recommendations in the A-C report.

Sheriff's Department's Response

The Sheriff's Department was provided with a draft of this report and sent a letter in response, which is incorporated on the following pages.

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[144] *See Manual of Policy and Procedures*, MPP 3-04/010.00 *Department Service Reviews.*

[145] It is possible for an employee to get a Service Complaint and Personnel Complaint based on the same incident.

OFFICE OF THE SHERIFF

COUNTY OF LOS ANGELES

HALL OF JUSTICE

ROBERT G. LUNA, SHERIFF

November 17, 2026

Mr. Eric D. Bates
Interim Inspector General
Office of Inspector General
County of Los Angeles
312 South Hill Street, Third Floor
Los Angeles, California 90013

Dear Mr. Bates:

RESPONSE TO THE OFFICE OF INSPECTOR GENERAL'S REPORT, REFORM AND OVERSIGHT EFFORTS: LOS ANGELES COUNTY SHERIFF'S DEPARTMENT, JULY THROUGH SEPTEMBER 2026

On November 6, 2026, the Office of Inspector General (OIG) provided the Los Angeles County Sheriff's Department with a validation draft of its report titled, "Reform and Oversight Efforts: Los Angeles County Sheriff's Department, July through September 2026," and requested a response by November 17, 2026, (Draft Report). We thank the OIG for the opportunity to comment on the Draft Report.

The Draft Report was distributed to the Department units responsible for the subject areas addressed in the report. Following a thorough review, the Department determined that, due to the number of comments received, it is appropriate to respond in letter form to address certain statements that may benefit from clarification or additional context, provide corrections where necessary, and identify areas where the Department's position or understanding differs from that described in the Draft Report.

The following sections address the specific areas identified during our review:

Deputy-Involved Shootings

On November 13, 2026, the Department submitted to the OIG requested edits to portions of the validation draft (Draft Report at Pages 3-7). The requested revisions included clarifications and corrections from the Detective Division's Homicide Bureau and were intended to ensure that the information ultimately provided to the public is clear, accurate, and reflects the most current information available. The Department further noted that information presented during the Critical Incident Review process may be preliminary, as investigations are often in their early stages and subject to additional clarification.

Recommendations for Sheriff's Department Training and Policies on Responses to Protests

The Columbus Model

The OIG recommends that the Department examine the Columbus Model as a potential approach to protest management and crowd-control operations (Draft Report at Pages 12-18). In support of this recommendation, the OIG notes that while the Department's current policies comply with applicable state law, greater emphasis could be placed on dialogue-based and engagement-focused strategies employed by the Columbus Police Department.

The Department recognizes the value of reviewing emerging practices and alternative public-order policing models. Simultaneously, the Department must also determine the suitability of any model to the Department's unique operational environment, jurisdictional responsibilities, resource demands, and the circumstances under which civil unrest occurs within Los Angeles County. Accordingly, the Department's assessment focuses on whether the principles and practices associated with the Columbus Model have been sufficiently demonstrated to address the full range of public-order challenges encountered within this jurisdiction.

Department's Preliminary Assessment of the Columbus Model

Based on the information presented in the OIG's report and the Department's independent review of available materials regarding the Columbus Model, the Department believes further evaluation is necessary before determining its applicability to Los Angeles County. First, while the model has shown promise

in promoting lawful demonstrations through communication and de-escalation strategies, it has primarily been implemented in jurisdictions significantly smaller than Los Angeles County in both population and geographic size. The scale of Los Angeles County presents unique operational challenges, including multiple jurisdictions, diverse communities, and the potential for simultaneous incidents of civil unrest. Additionally, the model has not been thoroughly validated in circumstances comparable to the sustained violence experienced during the June 2025 unrest in Los Angeles, which included assaults on law enforcement personnel, the use of incendiary devices and commercial fireworks, and extensive property damage.

Based on the Department's preliminary assessment, the Columbus Model may offer value as a complementary strategy for managing planned and peaceful First Amendment activities but should not be viewed as a substitute for established public-order response tactics and capabilities necessary to protect public safety, ensure officer safety, and restore order during rapidly evolving or violent incidents.

Los Angeles County Sheriff's Department Sheriff's Response Team

The Department agrees with the Draft Report that the Sheriff's Response Team (SRT) serves as the Department's primary specialized resource for crowd management and public-order operations and notes that, in addition to SRT training, 97 percent of Department personnel have completed Penal Code section 13652 and 13652.1 [Assembly Bill (AB) 48 (Kinetic Energy Projectile and Chemical Agent)] training.

The SRT operates with a limited number of full-time personnel supported by members serving in collateral assignments. As such, expanding the SRT's role beyond its current operational and training responsibilities would have resource implications that should be considered when evaluating additional Department-wide training requirements.

Recent Incidents

The OIG cites allegations from civil lawsuits involving protest-related incidents as examples of oversight concerns regarding the Department's crowd-management operations and interactions with members of the media.

The allegations described in this section reflect claims made by plaintiffs in civil litigation and should not be presented as established facts. The Department believes it is premature to rely on such allegations as evidence of deficiencies in policy, training, or operational practices absent a complete review of the available evidence and resolution of the underlying claims.

Conclusion

In its conclusion to the Columbus Model portion of the Draft Report (Pages 17-18), the OIG stated that while the Department's policies comply with state law, protest policing would benefit from a greater emphasis on the dialogue-led principles embodied in the Columbus Model, which it identifies as a potential guide for future protest-policing reforms and contrasts with traditional force-heavy crowd-control approaches.

The Department disagrees with the characterization that the SRT employs a "force-heavy" approach to protest policing. The SRT's mission, training, and operational philosophy emphasize lawful crowd management, communication, de-escalation, and the measured use of force only when objectively reasonable and necessary under the circumstances. These principles guide the SRT's efforts to facilitate lawful assemblies, protect constitutional rights, maintain public safety, and respond appropriately to evolving crowd conditions.

The Department agrees that communication, legitimacy, proportionality, and facilitation are important principles of effective protest management. However, those principles should complement, rather than replace, the operational capabilities necessary to protect lives, ensure officer safety, prevent property destruction, and restore public order when demonstrations escalate into unlawful or violent activity. From January 1, 2025, through November 30, 2025, approximately 661 identified protests, assemblies, and demonstrations did not require an SRT response, demonstrating that the SRT is not deployed as the default response to lawful public gatherings.

Department Engagement and Collaboration with Oversight Partners

Consistent with the Department's standing practice of engaging with its oversight partners on matters of operational interest and public concern, the Department welcomed the opportunity to discuss the Columbus Model and related crowd management concepts with OIG staff.

Following the OIG's request to meet with Department personnel knowledgeable about the Columbus Model, Emergency Operations Bureau (EOB) leadership coordinated an in-person meeting with OIG staff and SRT subject matter experts. During that meeting, EOB leadership and SRT personnel provided an overview of SRT's mission and operational responsibilities and engaged in a detailed discussion regarding the Columbus Model. Department representatives explained that while the Columbus Model offers certain benefits, it has historically been implemented at the station level and is best suited for that operational environment.

To further support transparency and understanding, the Department invited OIG representatives to attend an SRT-hosted training program conducted for outside law enforcement agencies. The training included instruction on force reporting procedures, report writing, constitutional policing principles, legal updates, crowd management formations, skills development, and less-lethal response options. Following the training, OIG staff expressed appreciation for the opportunity to attend, provided positive feedback regarding the training and instructors, and indicated an interest in arranging attendance for additional OIG personnel during future training sessions.

These efforts reflect the Department's commitment to maintaining an open and collaborative relationship with its oversight partners through continued engagement, information sharing, and opportunities for direct observation of Department operations and training.

Recommendations for Sheriff's Department Training and Policies on Responses to Protests

The OIG's Draft Report includes three recommendations related to protest-management practices, training, and policy development (Draft Report at Page 18). The Department has reviewed each recommendation and provides the following responses.

OIG Recommendation: The OIG recommends that the Department evaluate the Columbus Police Department's Columbus Model and consider training opportunities to enhance protest-management and crowd-control practices.

Department Response:

The Department has conducted a preliminary assessment of the Columbus Model, as discussed above, and believes further evaluation is necessary before determining its applicability to Los Angeles County. Any decision regarding additional training opportunities should be based on a demonstrated operational benefit and the model's ability to address the unique public-order challenges encountered within the Department's jurisdiction.

OIG Recommendation: The OIG recommends that the Department revise its policies and training governing flash-bang devices to ensure compliance with Senate Bill 937 before its effective date.

Department Response:

The Department recognizes the importance of ensuring compliance with Senate Bill 937 before its effective date. The Department has prepared a draft policy which has been forwarded to labor, per the Department's standard practice. Any necessary policy and training revisions will be incorporated into the Department's existing policies while maintaining operational effectiveness and officer safety.

OIG Recommendation: The OIG recommends that the Department provide Department-wide, scenario-based training on legal requirements governing crowd-management operations, including protections for members of the news media

Department Response:

The Department recognizes the importance of ensuring that all personnel understand the legal requirements governing crowd-management operations, including protections afforded to members of the news media. In addition to the comprehensive scenario-based training provided to members of the SRT, the Department has implemented new media policies governing interactions with members of the media and provides recurring Department-wide briefings on those policies. Most recently, a Department-wide reminder was distributed via global email on October 30, 2026, reinforcing personnel's responsibilities regarding media access and protections.

Update on Deputy Gang Investigations

In the Draft Report, after referencing 47 supervisory inquiries related to law enforcement gangs were opened (Draft Report at 19), the Draft Report references closed and pending inquiries. Specifically, the Draft Report states: "Of those [47 inquiries], 32 inquiries are closed, with 20 referred to IAB" (Ibid). It would be more accurate to state that 20 inquiries were sent to the appropriate Division Chief with a recommendation that the inquiry be referred to Internal Affairs Bureau (IAB) for an administrative investigation. The Department believes it is important to clarify that it is ultimately the Division Chiefs of the impacted Divisions that make the decision to refer a matter to IAB.

Next, the Draft Report states that of the 20 inquiries referred to IAB, "IAB opened investigations on 18 of the referrals from OCP" (Ibid). It would be more accurate to state that: "IAB opened administrative investigations on 18 of the inquiries based on referrals by the appropriate Division Chiefs, with two inquiries pending decision at the conclusion of the reporting period." The Department believes this is important to clarify the two outstanding matters were pending, and to ensure that there is no misunderstanding as to what happened to the two remaining inquiries since no decision had been made at the time of reporting.

The Draft Report next states: "The IAB investigations of 14 of the referrals resulted in discipline in 5 cases; 5 investigations remain open" (Ibid). The Office of Constitutional Policing (OCP) proposes the following sentence: "Of the 14 fully closed IAB investigations opened following an OCP inquiry, 5 administrative investigations resulted in discipline. Five administrative investigations remain pending with IAB." The Department believes it is important to clarify the above information.

The Draft Report does not state that the OIG reviewed all of OCP's inquiries and found them to be very thorough, as the Interim Inspector General publicly stated at the September 17, 2026, Civilian Oversight Commission meeting. The Department requests that the OIG include its determination that the inquiries were thorough.

The Draft Report states that: "To date, the Sheriff's Department has not identified a group by name, or other indicia, that meets the definition of a law enforcement gang under Penal Code section 13670" (Draft Report at 20). The

Department re-iterates its position that it is not appropriate to conflate identification of specific groups with Penal Code section 13670 because the statute does not require a named group (the group "may identify themselves by name and may be associated with an identifying symbol"). Narrowing the statute to limit its applicability undermines its effectiveness.

The Department meets its statutory obligation by investigating every allegation regarding the existence of a group or allegation of employee membership under the Penal Code and the Manual of Policy and Procedures (MPP), Sections 3-01/050.82 and 3-01/050.83, regardless of whether the allegation includes a named group or a specific individual. Any other approach is too narrowly focused on names and will avoid identifying significant conduct that constitutes a violation of the Penal Code and Department Policy.

The above response should not be interpreted as a reluctance by the Department to name groups. In fact, the Department has named groups in recent years. Specifically, the Department identified the Industry Indians during an administrative investigation where the employees were determined to have violated the clique policy (MPP Section 3-01/050.83).[1] It is the Department who identified this group.

The Sheriff's Department Automatic License Plate Reader Audit

Regarding the OIG's assessment of the Automatic License Plate Reader (ALPR) Audit of query justifications (Draft Report at Pages 21-22), the Department first notes an apparent inconsistency in the report. Specifically, the report states, "the audit did not confirm that each query was connected to a legitimate law enforcement purpose" and that it "reviewed whether the stated justification was adequate, not whether it was true." The report then states that "a query could appear justified on its face but still constitute misuse if its underlying purpose was for a legitimate law enforcement purpose." As written, the statement appears contradictory and creates uncertainty as to how the audit reached its conclusion.

Recommendations for Ensuring Compliance with ALPR Laws and Policies

The Draft Report made three recommendations aimed at strengthening compliance with ALPR laws, policies, and audit reporting requirements (Draft Report at Page 22).

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[1] This was prior to MPP Section 3-01/050.82 being adopted.

OIG Recommendation:

The OIG recommends that all ALPR users be trained to document a justification for each query, including the specific legitimate law enforcement purpose and any case information connecting the query to an investigation.

Department Response:

The Department recently implemented updated ALPR Privacy Policy Training through a mandatory online learning platform for all personnel who have, or may obtain, access to an ALPR system. The training specifically instructs users to document the justification for each query, identify the legitimate law enforcement purpose supporting the query, and include applicable case information associated with the investigation. Additionally, the audit's review of ALPR queries included examination of the documented justification and associated case number. Accordingly, the Department believes this recommendation is addressed through its existing training and documentation requirements.

OIG Recommendation:

The OIG recommends that the Department's ALPR audit process verify that audited queries are connected to an investigation or other legitimate law enforcement purpose and assess whether the documented justification accurately reflects the basis for the query.

Department Response:

As noted by the OIG, there is "no reason to suspect widespread misuse" of the ALPR system. The Department's audit found that all sampled queries were ultimately supported by a legitimate law enforcement purpose following review and documented follow-up, where necessary. The Department will continue to assess query justifications against available case information and conduct additional review when circumstances indicate potential misuse. If there is reason to believe a query was conducted for an unauthorized purpose, the matter will be investigated and addressed as appropriate.

OIG Recommendation:

The OIG recommends that the Department report information identified in the Board motion, including a summary of ALPR data or system access logs that identifies the requesting entity, date range, and statutory authority relied upon for access to or disclosure of ALPR information.

Department's Response:

As part of the audit process, the Advanced Surveillance and Protection Unit reviews ALPR audit logs which include the requesting entity, applicable date range, and the justification and associated case information supporting access to ALPR data, consistent with applicable law and the Department's ALPR Privacy Policy. Authorized access to ALPR data requires documentation of a legitimate law enforcement purpose and related case or file number, whether the user is a Department member or an authorized user from a partnering public agency operating under an inter-agency agreement. While this information was reviewed during the audit, it was not separately summarized in the audit report because all queries are evaluated under the same audit standards regardless of the requesting entity.

Minimizing Racial Disparities in Stops

The Draft Report provides an overview of the findings of the Justice Navigator Assessments (JNA) conducted by the Center for Policing Equity (CPE) for the Department's Carson, Century, Compton, East Los Angeles, Industry, Lakewood, South Los Angeles, and Temple Sheriff's Stations for the period between 2018 and 2022.

The Draft Report does not state that Sheriff Robert Luna requested CPE's review as part of the administration's efforts to inform best practices in the process of reforming operations. Further, the period covered by the CPE analysis involved data that predates Sheriff Luna's administration and therefore does not reflect the critical work that has taken place to address many of the concerns raised since that time.

In addition to the age of the dataset in question, there are also issues related to the methodology utilized in the analysis. As noted by both the Department and CPE, an analysis based solely on resident demographics within the station

patrol area does not address crucial relevant information. For example, and as mentioned in the Draft Report, such an analysis does not account for all those commuting through or otherwise visiting a patrol area. Therefore, correlations made in the report may be affected by this incomplete data. While these impacts vary vastly by geography, they can nevertheless be significant in some locations. Finally, the dataset also does not distinguish between officer-initiated calls and those initiated by technological platforms utilized in many of the Department's contract cities (e.g. ALPR or gunshot detection systems).

The recommendations across all eight JNA reports remain consistent with the work the Department is undertaking to ensure that police services are delivered across Los Angeles County in a manner that is fair, equitable, transparent, and accountable to our communities and oversight partners. They are also consistent with the Department's efforts working towards compliance with the provisions of the Antelope Valley (AV) Settlement Agreement, which have been implemented beyond the AV's Lancaster and Palmdale Sheriff's Stations, and have led to substantive changes in policy, training, data-collection, auditing procedures, and engagement efforts Department-wide, including the Risk Management Forum (RMF) process described above. None of this is mentioned in the Draft Report.

OIG Recommendation:

The OIG recommends that the Department evaluate whether traffic stops for equipment, registration, and similar non-moving violations meaningfully advance public safety and, where appropriate, consider alternative enforcement methods in lieu of a traffic stop (Draft Report at page 33).

Department Response:

The Department is working diligently to counter potential bias through policy implementation, enhanced training, supervisory oversight, compliance audits, and better documentation rather than by eliminating the practice entirely. Traffic stops are a constitutionally permissible method for vehicle code enforcement and can be an important aspect of investigative discretion and crime deterrence. If a deputy has probable cause to believe a traffic violation occurred, then a deputy's ability to act on suspicious circumstances or investigative criminal activity before a more serious crime or violent act occurs is an important aspect of public safety.

At the same time, the Department recognizes its obligation to ensure unbiased law enforcement activities. The efforts described below address this aspect of the Department's response.

OIG Recommendation:

The OIG recommends that the Department review its practices regarding consent searches and deputy safety searches, including consideration of requiring reasonable, articulable suspicion before requesting consent to search and ensuring that deputy safety searches are supported by documented facts (Draft Report at Page 33).

Department Response:

The Department is continuously reviewing and assessing practices as they relate to consent and deputy safety searches. The Department's policies on Stops, Seizures, and Searches (MPP Section 5-09/520.05) and Bias - Free Policing (MPP Section 3-01/000.05), for example, both provide that requests to conduct a consent search must be "reasonable, and a deputy must be able to articulate a valid reason under law and policy for initially having stopped the individual." The Department's policy on Deputy Stops - Government Code Section 12525.5 (MPP Section 3-01/140.00) establishes procedures for personnel to follow in order to comply with California Government Code section 12525.5 and California Vehicle Code section 2806.5, outlining practices including articulation of reasonable suspicion and documentation of searches.

The AV Settlement Agreement also contains a number of provisions directly related to consent searches, which the Department has now reached compliance or sustained compliance with. These include improved collection of data via the Sheriff's Automated Contact Reporting system, outreach regarding the right to revoke consent, recording of requests to search, and prohibiting the use of protected characteristics in exercising discretion to conduct searches.

In its June 2026 report, the AV Monitoring Team (MT) indicated that:

> "[b]ased on MT observations, case reviews, audit findings, supervisory oversight, risk management practices, and demonstrated leadership commitment, LASD has achieved

> sustained compliance" in the search-related provisions of the Settlement Agreement, and that "the MT has not identified any patterns, trends, or systemic concerns that might indicate that LASD moved out of compliance with these provisions. Additionally, the Department has demonstrated its ability to identify, monitor, and address potential issues through multiple layers of accountability and oversight."[2]

The Department's efforts in reaching compliance with the provisions of the AV Settlement Agreement continue to inform best practices, policy updates, and associated training that is implemented Department-wide, and efforts to ensure that deputies are trained and consistently briefed on appropriate practice in this area continue.

OIG Recommendation:

The Draft OIG Report recommends that the Department conduct focused reviews of patrol stations identified as having the largest disparities in search rates among racial and ethnic groups, including an examination of patrol station practices, supervisory oversight, and deployment decisions that may contribute to those disparities (Draft Report at Page 33).

Department Response:

For the last several years, the Department has been evaluating patrol station stops policies, stop data, and the impact of these practices on public safety and the community in its semi-annual RMF. This includes a review of disparities, explanations relating to any disparities, an examination of patrol station practices, supervisory oversight, and deployment decisions.

The RMF is a structure through which Captains must present their data, trends, and community concerns to the Undersheriff, the Assistant Sheriff for their Command, and the Chief of their Division. Department leadership then questions the captains on their data trends, risk issues, and community concerns.

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[2] https://lasd.org/wp-content/uploads/2026/07/AVDOJ_COLA_Semi-Annual-Report_June_2026_70_07282026.pdf.

In 2025, the RMF process was updated to modernize the process, improve efficiency, ensure more accurate data, and better support Department operations. First, the reporting timeframes were standardized throughout the Department so all units now follow uniform annual and semiannual periods (with the first RMF of the year covering the entire prior calendar year, and the second RMF covering the first 6 months of the current calendar years), allowing clearer data comparisons across the various units of the Department.

The second improvement was to standardize the RMF data being used. Previously, most units self-reported their data. Now, the data is automated, with centralized Power BI dashboards developed by OCP. This standardized the data throughout the Department, reducing variability, and improving reliability.

The RMF presentations were restructured so each patrol station's information is reviewed comprehensively, with an added emphasis on identifying trends, contextualizing data, linking community concerns to station efforts, and focusing on risk related impacts.

OIG Recommendation:

The Draft OIG Report recommends that the Department consider implementing recommendations contained in the OIG's prior report, *Addressing Racial Disparities in Traffic Stops*, including recommendations related to traffic enforcement practices and consent searches (Draft Report at Page 33).

Department Response:

The Department continues to reform via policy adjustments, enhanced training, supervisory oversight, compliance audits, improved documentation, and implementation of updated technology that will provide more accurate and timely data for monitoring impacts of these efforts. Along these lines, several of the recommendations in the OIG's prior report, *Addressing Racial Disparities in Traffic Stops,* have been implemented or partially implemented in the years since its publication in 2023. Summaries of the recommendations along with status updates are as follows:

- Department policies, many of which have been updated in recent years and are outlined above, address important aspects of the recommendations, including articulation of reasonable suspicion, body camera recording, documentation, etc.

- Department policy outlines how stops are to be conducted appropriately and in a manner that is compliant with the law.

- The Department has updated the Department's TR-130 form and Newsletter 23-06 – AB 2773 (2022) – Stating and Documenting the Reason for the Stop.

The Department collects Department-wide stop information, which is now publicly available via the Racial and Identity Profiling Act (RIPA) Dashboard.[3] Information is compiled and analyzed for all Department patrol divisions throughout the year during the RMF process, and is also analyzed in various other formats including by the Audit and Accountability Bureau in the Department's Stops, Detentions, and Use of Force reporting.

Status of Labor Negotiations on Measure R and AB 847

The Draft OIG Report stated that it inquired with County Counsel regarding the status of ongoing meet-and-confer discussions related to Measure R and AB 847, including whether OIG staff would continue to participate in those negotiations, and whether the Department's Prohibited Cliques policy implicated conditions of employment. The OIG Report notes that no response has been received. While these inquiries were directed to County Counsel, the Department is aware that a meeting on these topics is currently being scheduled (Draft Report at Pages 33-34).

Department Response:

The Department will continue to rely on the advice of County Counsel and, where appropriate, the advice of the Chief Executive Office, on matters relating to the meet and confer process. This is particularly true with respect to matters that involve multiple county agencies. Finally, with respect to the "Cliques" policy, the Department has completed its

[3] https://lasd.org/transparency/ripa-dashboard/.

meet and confer process and the new policy has been published and is implemented.

CUSTODY DIVISION

The OIG devoted a substantial portion of its quarterly report to Custody Division operations (Draft Report at Pages 34-75), highlighting a variety of issues affecting custody facilities. The following responses from the respective Custody units are to focus on a few of the issues presented, and reflects the Department's commitment to transparency by providing context, clarification, and substantive responses to the issues raised.

Staff Searches

Regarding the OIG's observation that staff searches were not visible in the reviewed Closed-Circuit Television (CCTV) footage for Pitchess Detention Center (PDC)-South Facility (Draft Report at page 48), the Department would like to clarify that staff searches at PDC-South are conducted in a designated administrative area outside the view of CCTV cameras and the incarcerated population. As such, the absence of observed searches in the CCTV footage reviewed by the OIG does not establish that staff searches were not conducted.

Recommendations for Contraband Detection to Prevent Overdose Deaths

The OIG recommended that the Department explore expanding the Custody Investigative Services (CIS) Unit- Canine Unit (Draft Report at Page 50).

The Department supports the OIG's recommendation to strengthen contraband detection capabilities through the expansion of the CIS K-9 Unit. Increasing K-9 resources will enhance the Department's interdiction efforts by increasing detection capacity, expanding operational coverage, and providing greater flexibility to conduct proactive, intelligence-driven searches throughout custody facilities, station jails, and courthouses.

Additional K-9 teams can enable more frequent and strategically coordinated search operations, strengthen deterrence efforts, and improve the Department's ability to identify and address potential security threats before they escalate into significant incidents. The expanded capability can also support investigative operations, disrupt contraband distribution networks,

and reduce the availability of dangerous substances within custody environments.

The Department will continue evaluating opportunities to expand and strategically deploy K-9 resources in support of its contraband interdiction and facility safety objectives.

Classification

Regarding the OIG's concerns about the privacy of K6G and Gender Identity Interview (GII) interviews (Draft Report at Page 62), Population Management Bureau (PMB) staff met with members of the OIG to discuss the feasibility of conducting K6G interviews during the classification process.

Following that discussion, PMB is evaluating whether classification personnel could assume these additional responsibilities without adversely affecting overall processing times. This assessment would also include determining whether classification personnel possess the necessary qualifications, skills, and experience to appropriately conduct the interviews. Currently, Inmate Reception Center (IRC) sergeants conduct the Preliminary GII at IRC Booking in a segregate area to provide privacy during the interview process.

Reducing Harms for Incarcerated Transgender, Gender-Diverse, and Intersex People

In its validation draft, the OIG discusses safety in K6G dorm housing and the accessible showers (Draft Report at Pages 63-66).

Leadership at the Men's Central Jail (MCJ) acknowledged that designated shower times alone do not ensure individual shower access. Accordingly, K6G booth personnel have been directed to announce and monitor shower periods, verify single occupancy, and document completion in the e-UDAL.

To improve privacy, MCJ replaced a removable shower curtain with a fixed partition. Following review, the Office of Prison Rape Elimination Act (PREA) Compliance recommended enlarging the partition, and the Facilities Services Bureau is evaluating the modification. The MCJ leadership team will consult with the Office of PREA Compliance before future housing-area modifications are completed.

Unauthorized shower coverings and obstructions are removed during routine and monthly large-scale searches.

Meal Preparation and Distribution at Men's Central Jail

The OIG raised several concerns regarding meal preparation and distribution at MCJ (Draft Report at Pages 67-69).

The Department appreciates the OIG identifying the meal-interval concern. Leadership at MCJ determined that breakfast deliveries required individual packaging upon arrival, delaying distribution. In coordination with the Food Services Unit, MCJ arranged for meals to arrive pre-bagged and ready for service.

Conclusion

The Department recognizes the importance of the OIG's quarterly reports in informing the Board of Supervisors and the public regarding Department operations, policies, and initiatives. We acknowledge the effort required to develop these reports and the many communications and activities that occur during the reporting period. In offering the comments above, the Department seeks to provide additional context, clarify factual matters where appropriate, and promote a complete and accurate understanding of the issues addressed in the report, thereby reducing the potential for misunderstandings by both the OIG and the public.

If you have any questions or concerns, please contact Commander Ernest Bille, Office of Constitutional Policing, at (323) 307-8358.

Sincerely,

ROBERT G. LUNA, SHERIFF

April Tardy

APRIL L. TARDY
UNDERSHERIFF